Methadone Maintenance Treatment:

Barriers to, and incentives for, the transfer of opioid-dependent people from secondary care to primary health care

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Report on a collaborative project involving the Goodfellow Unit at the Department of General Practice and Primary Health Care, School of Population Health, The University of Auckland and the Auckland Methadone Service at the Community Alcohol and Drug Service, Waitemata District Health Board.

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The opinions expressed in this report are those of the authors and do not necessarily represent those of the Mental Health Commission.

Table of Contents

List of Figures **4**

List of Tables **5**

Executive summary **7**

Research team **13**

Investigators *13*

Consultancy *14*

Abbreviations **15**

Introduction **16**

The New Zealand situation *16*

Over-view of international literature *19*

Hypothesis **23**

Aim **23**

Objectives **23**

Methodology **24**

Setting *24*

Consultation and ethics *24*

Participants *24*

Questionnaire development *25*

Participant recruitment and data collection *26*

Data analysis.....27

Results.....**28**

AMS Clients *28*

Description of AMS client sample 28

Attitudes of clients towards transferring..... 31

Barriers for clients to transfer 32

Client attitudes towards receiving GP care 33

Client likelihood of transferring 34

Client views on proposed interventions 35

Thematic analysis of qualitative data from clients..... 36

AMS specialist staff.....*37*

Description of AMS staff sample 37

AMS staff views on the transfer process 38

AMS staff views on proposed interventions 39

Thematic analysis of qualitative data from AMS staff..... 40

GP patients *42*

Description of GP patient sample..... 42

GP patients' reasons for transferring 44

Patient perceptions and experiences of GP care..... 45

GP and specialist service comparison by patients 46

GP patients' views on proposed interventions 47

Thematic analysis of qualitative data from GP patients 48

GPs *50*

Description of GP sample 50

GP views of MMT patients and their treatment..... 52

Barriers for GPs accepting further patients 53

GPs' views of barriers for clients transferring to primary care 53

GP willingness to take on more MMT patients..... 54

GP views on proposed interventions 54

Thematic analysis of qualitative data from GPs..... 55

Discussion **57**

Summary of findings *57*

Strengths of the study *60*

Limitations of the study *60*

Key findings *61*

Recommendations **64**

Appendix A: Participant Information Sheets **67**

Appendix B: Questionnaires **72**

Appendix C: Log forms for AMS staff & GPs recruiting clients / patients into study ... **83**

Appendix D: Free-text responses coded into themes **86**

1 Thematic analysis: AMS clients *87*

2 Thematic analysis: Specialist staff *90*

3 Thematic analysis: GP patients *93*

4 Thematic analysis: GPS *103*

Appendix E: Indicators of MMT stability / instability **106**

References **108**

List of Figures

Figure 1: Age and gender of AMS clients 29

Figure 2: AMS clients' attitudes towards transferring to a GP..31

Figure 3: AMS clients' likelihood of transferring to a GP in the next six months 34

Figure 4: Age and gender of GP patients..43

List of Tables

Table 1: Length of time on MMT (AMS clients) 29

Table 2: Demographics of AMS clients and study sample 30

Table 3: AMS clients' barriers for transferring 32

Table 4: AMS clients' attitudes towards GP care 33

Table 5: AMS clients' views of proposed interventions 35

Table 6: Other reasons for clients not transferring to a GP 36

Table 7: Number of clients per staff member with a caseload 38

Table 8: AMS staff views on the transfer process 39

Table 9: AMS staff's views of proposed interventions 40

Table 10: Other reasons for AMS clients not transferring to a GP 41

Table 11: Other ideas/incentives that might encourage clients to transfer to a GP 42

Table 12: Length of time on MMT (GP patients) 44

Table 13: GP patients' reasons for transferring 45

Table 14: GP patients' perceptions and experiences of GP care 46

Table 15: GP patients' views of proposed interventions 47

Table 16: GP patients' reasons for transferring to GP care 48

Table 17: Reasons for stating GP care was 'better', 'worse', or 'neither better nor worse' 50

Table 18: Number of MMT patients per GP 51

Table19: Length of time prescribing 51

Table 20: GP views of MMT patients and their treatment 52

Table 21: Barriers to GPs accepting further MMT patients 53

Table 22: GPs' views of barriers to client transfer 54

Table 23: GP views of proposed interventions 55

Table 24: GPs' views on what could be done to encourage MMT patients to transfer to GP care.....56

Executive summary

Introduction

There is evidence that providing care for opioid-dependent people on methadone maintenance treatment (MMT) in primary health care settings, supported by specialist services, has beneficial outcomes.

Aim

The aim of this study was to explore the barriers to, and incentives for, the transfer of opioid-dependent people from secondary to primary health care for their MMT within the greater Auckland region.

Method

The project was conducted by the Goodfellow Unit, The University of Auckland and the Auckland Methadone Service (AMS), Waitemata District Health Board. The four groups of participants were: AMS clients deemed stable for transfer by their case managers; AMS specialist staff; MMT patients with authorised general practitioners (GPs) in the Auckland region and Auckland GPs authorised by the AMS to prescribe MMT to patients.

Self-completion questionnaires were distributed to each group, and included both quantitative and qualitative questions.

Results

AMS Clients

Twenty-three AMS clients completed questionnaires from an estimated pool of 95-100 clients deemed stable. Seventy-eight percent currently had a GP and 30% had previously

attended a GP for MMT. One third stated their case manager was not encouraging them to transfer and half were not keen to transfer.

Key barriers to transfer included financial reasons, not wanting their GP to provide their MMT and confidentiality concerns. The majority did not expect a GP to be as knowledgeable as their case manager and there were concerns about GP attitudes and the potential for an inferior service. Almost half reported that they were unlikely to transfer in the next six months.

Respondents were most supportive of the following interventions to encourage transfer: knowing that they could try it out and return to the specialist service; an information sheet/ handbook and talking to others who had already transferred.

AMS specialist staff

Questionnaires were completed by 20 of 26 eligible AMS staff. Eighty percent of staff were supportive of stable client transfer to GP care; however, 40% of staff with a caseload were not actively encouraging their stable clients to transfer. There were concerns about GPs' attitudes towards MMT clients. All agreed that many stable clients showed little interest in transfer and many believed some clients identified as 'stable' were not ready to transfer.

AMS staff considered the most helpful incentives to transfer were: staff accompanying clients on their first visit; short education sessions; information sheets/handbook; talking to others who had already transferred, and opportunity to return to the specialist service.

GP patients

AMS estimated there were 274 stabilised MMT patients attending 108 authorised GPs. GPs distributed questionnaires to their patients and 74 were returned. Three quarters rated seeing their GP as better than attending the specialist service and the majority stated it was very unlikely that they would return to the specialist service in the next six months. Dealing with one person for all their healthcare needs was their major reported motivation for transferring to GP care. Freeing up a space for someone else on the waiting list and a desire to move from specialist drug services into a more mainstream health service were also important reasons for transferring.

Helpful interventions for transfer were: information sheet/handbook; the opportunity to talk to others who have already transferred and the ability to return to the specialist service. Fifty-four percent considered having somebody to accompany patients on their first visit could be helpful.

GPs

Questionnaires were completed by 77 of the 104 eligible GPs. There was a high level of support for the transfer of MMT patients to primary health care and confidence that MMT patients received a good service from their practice. The main barriers identified by GPs to accepting more MMT patients were that these patients tended to be disorganised, had problems with prescriptions and unpaid bills. Rushed appointments were identified by GPs as a minor issue. Forty-five percent of GPs were willing to take on further MMT patients in the next six months.

Information sheets/handbook and the ability to return to the specialist service were interventions rated highly by GPs as incentives to transfer.

Strengths of study

Simultaneous perspectives on secondary to primary health care transfer process from four main stakeholders; triangulation of quantitative and qualitative data; rich qualitative dataset; high response rates from AMS staff (77%) and GPs (74%).

Limitations of study

Small sample sizes; relatively low response rates of AMS clients and GP patients; lack of denominator figures for these two groups and focus on one region in NZ makes generalisations difficult.

Key findings

1. Despite governmental policy to transfer stabilised MMT patients from secondary to primary health care, and the training of a primary health care workforce (GPs, practice nurses (PNs) and community pharmacists) there are significant barriers to patient transfer.
2. Funding issues contribute to discouragement of growth of GP prescribing and client willingness to attend. Capped funding limits new untreated clients entering the specialist service when a client transfers to primary health care.
3. Both AMS clients and GP patients may not be aware that patients under GP care for MMT can return to secondary care or receive specialist assistance if their condition deteriorates.
4. Some specialist service staff and AMS clients consider transfer to an authorised GP may result in lower quality of care. However most MMT GP patient respondents were very satisfied with the standard of care provided by their authorised GP.

Recommendations

These recommendations have been extrapolated from the feedback from the research. We, however, are aware that some of these recommendations may already be in place within some NZ specialist services.

- That MMT clients are encouraged at the outset to incorporate the progression from secondary to primary health care in their treatment planning.
- That consideration is given to training and upskilling specialist services staff in the transfer process including the reassurance that most GP patients speak positively about the quality of care they receive from trained authorised GPs.
- That specialist services place greater emphasis on providing an integrated transition period for MMT clients transferring from secondary to primary health care including ways of assisting clients to locate authorised GPs in their region and accompanying clients on their first visit.
- That local transfer guidelines be implemented alongside national guidelines for clients, specialists and primary health care staff to support safe, appropriate and best practice transfer from secondary to primary health care.
- That specialist services have systems in place for ongoing consultation with authorised GPs.
- That the identified barrier of specialist service capped funding for MMT clients (specialist service and GP) is reviewed as to whether this is the best way to deliver the service.
- That options for financial assistance for MMT clients who transfer from secondary to primary health care are explored.

- That specialist services develop processes that support clients to have greater participation in and responsibility for their own treatment and recovery pathway.
- That additional funding including remuneration for GPs to cover administration costs for providing services to their MMT patients is explored and resourced.
- That dissemination of these findings to the Ministry of Health and other key stakeholders may assist review of existing national guidelines, local policies/protocols and training curricula to support best practice transfer.
- That further research is conducted to develop and evaluate the effectiveness of interventions to improve MMT clients transfer from secondary to primary health care.

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Abbreviations

AMS	Auckland Methadone Service
CADS	Community Alcohol and Drug Service
CM	Case manager
DHB	District Health Board
GFU	Goodfellow Unit
GP	General practitioner
MMT	Methadone maintenance treatment
MO	Medical officer
NZ	New Zealand
MOH	Ministry of Health
PHO	Primary Health Organisation
PN	Practice nurse
UK	United Kingdom
US	United States

Introduction

There is evidence that providing care for methadone clients in primary health care, supported by specialist services, has beneficial outcomes for clients.

The New Zealand situation

In the early 1970s some NZ GPs started to prescribe methadone for opioid-dependent patients. The Department of Health expressed concern that the lack of facilities for monitoring was likely to lead to methadone abuse and advised GPs to refer patients to psychiatric services.[1] In 1971 an Auckland GP, Dr Roche, set up a methadone-prescribing clinic with associated group therapy. His initial attempts to insist on a reducing dose methadone withdrawal programme proved unsuccessful.[2] However his move to a MMT programme was considered successful with most patients becoming employed and all demonstrating mental and physical improvements. Over the next two decades, MMT in NZ was largely delivered in specialist secondary care clinics, shifting over time from daily dispensing by clinics to the use of community pharmacies.[3] Tauranga was an exception with a GP-based methadone programme being run since the 1970s. In the 1990s relatively few NZ GPs had experience of managing MMT patients. Specific authority was needed to prescribe controlled drugs for the treatment of dependency under Section 24 of the Misuse of Drugs Act.

The Wellington Drug and Alcohol Services pioneered care of MMT patients with GPs, and in 1994 it reported that 25% of Wellington MMT patients were under the care of authorised GPs.[3] Some of the authorised GPs at that time recognised the disparity between the free service provided by the alcohol and drug service and the fee-for-service required by the

GP. They reported that while they saw significant advantages in a patient's GP managing their MMT, the fee acted as a barrier for some.[4]

An estimated 13,500 to 26,000 people were opioid-dependent in NZ, and this number is predicted to grow by 15% per annum.[5] By 1996, approximately 2,500 opioid-dependent clients were on methadone treatment.[6] According to a recent MOH report, there were 3865 funded methadone places in treatment programmes in 2002/2003.[7]

In 1996 it was identified that service delivery could be improved if the majority of clients, after initial registration and assessment at a specialist service, were cared for directly by GPs to whom the specialist service would provide highly accessible backup consultation.[8] Identified benefits of GPs providing care of stabilised clients include maximising access to limited specialist services for those most in need of intensive specialist intervention, with resultant cost-saving and reduction of waiting lists, although there is no evidence to support these claims in a NZ context.

The desire to have comprehensive services for opioid-dependent people in NZ runs in accord with the Opioid Substitution Treatment New Zealand Practice Guidelines, which focuses on harm reduction and stabilisation of the client's health status.[8] In Auckland MMT is delivered by approved specialist alcohol and drug services, approved medical practitioners and by authorised general practitioners (GPs) to clients whose dependency condition has been stabilised.[8] Given the estimated number of opioid-dependent people (13,500-26,000) and the number receiving MMT (<4000) there is likely to be a significant pool of untreated people who pose a risk both to themselves and to the community.

Choice, acceptability, accessibility and appropriateness are all important issues when it comes to the provision of healthcare to any patient, and MMT patients are no exception. Improved social integration by normalisation of the delivery of treatment (not having to attend a ‘drug clinic’) is also widely recognised.[9] 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.’[8]

The Auckland Methadone Service (AMS) is funded to care for a maximum of 989 MMT clients (i.e. the total number is capped). This figure includes both clients directly under the care of the specialist service, and those who have transferred to primary health care. The latter have their methadone prescribed by a GP who is authorised by the specialist service. Data are exchanged between the GP and the specialist service and consultation occurs via a GP liaison coordinator. Additionally the specialist service will manage individual cases when issues arise such as overseas travel or pregnancy. When clients de-stabilise whilst on the GP programme, the GP can be supported to re-stabilise the client or more commonly, the client is returned to the specialist service for a further period of care.

In 2000 a National Opioid Treatment Training Programme in primary health care was introduced in NZ as a strategy to recruit, train and support a primary health care workforce (GPs, practice nurses (PNs) and community pharmacists) involved in opioid substitution treatment such as MMT. The Goodfellow Unit at the University of Auckland delivers this programme throughout NZ, with course attendance free to all participants.[10] Both Otago and Auckland Universities run post-graduate courses on the neurobiology of addiction and management of opioid dependence. However, training GPs, PNs and community

pharmacists to manage opioid-dependent clients in the primary health care setting is unlikely to increase the involvement of the primary health care sector in managing these clients if there are significant barriers to transfer.

Over-view of international literature

An evaluation of "shared care" (GPs treating patients with specialist service support) of methadone maintenance treatment (MMT) patients between general practitioners (GPs) and the Community Drug Problem Service in Edinburgh, Scotland, identified advantages such as better-trained GPs; the improved capacity of the specialist service to cope with referrals; the normalisation of a drug-user's self-perception and cost benefits.[9] Disadvantages identified were resources expended on reluctant GPs; more variation in prescribing practice; difficulty for specialist service handing control over to GPs; 'street leakage' of methadone and more opportunities for patient deception (duplicate registration).

In Glasgow a GP-centred scheme was established where GPs were responsible for methadone prescribing with support from the specialist Glasgow Drug Problem Service where needed.[11] This has been reported to be a successful scheme in a region where specialist services did not have the capacity to meet the needs of large numbers of opioid-dependent patients. It was followed by a call for similar models to be set up in other regions in the United Kingdom (UK) to "allow large numbers of drug misusers to be treated economically in the community by general practitioners".[12]

Since 1999 shared care of MMT patients has been introduced in other regions of Scotland and England, with the specialist drug service performing the initial assessment, initiating a care plan and then passing on the care to the GP once the patient is 'stabilised'.[13] GP

education and financial incentives have been shown to improve prescribing practice.[14] As well as GP training, access to specialist advice and use of structured protocols are considered advantageous features of these shared-care schemes.[15] A recent qualitative study of Scottish GPs found they are becoming more confident with MMT but a lack of sufficient knowledge and skills was still identified.[16]

A large variation in dispensing practice by community pharmacists in Scotland with respect to supervision of methadone consumption has been described.[13] Supervised consumption in community pharmacies has been identified as a means of minimising diversion of methadone to illicit markets and reducing methadone-related deaths.[14]

In England MMT has been shown to reduce drug abuse deaths.[17] However, revoking of the requirement for national registration of opioid-dependent patients in England and Wales, and lack of integration between specialist services and GP, has resulted in reported cases of duplicate prescribing, hence increasing the risk of methadone over-dose.[18]

Studies indicate that outcomes in primary health care may be better than specialist care. A longitudinal cohort study in England found that patients maintained on MMT for one year in primary health care achieved improvements on a range of harm reduction outcomes similar to those shown in studies of more highly structured secondary care services.[19] Another two-year prospective follow-up study of English MMT patients treated either by GPs or specialist services showed a reduction in illicit drug use, injecting, sharing needles, psychological and physical health problems and crime in both settings.[20] Reductions in problem behaviours were similar for clinic and GP patients, although where differences were found, there was greater reduction in problems among the GP patients. Furthermore,

in addition to positive outcomes from primary health care provision of MMT, GPs are able to respond to the whole area of general health and thus provide holistic healthcare for their MMT clients. However it should be noted that there are funding, service structure and drug-specific differences between the UK and NZ settings.

Barriers to primary health care may be related to GP attitudes. A study of the attitudes of 31 GPs and their practice staff in Dublin on the care of stabilised MMT patients in their practices found that there was generally a positive attitude prior to the introduction of the service. Six months after the service was introduced fewer GPs perceived any difficulties in delivering the service and all continued to participate in the scheme.[21]

A shared care service in Birkenhead, UK, has been shown to be cost-effective compared to utilisation of secondary care services.[22] These studies further support the feasibility and effectiveness of MMT within a primary health care setting.

In the United States (US) there is a shortage of specialist services and it has been estimated that MMT is available to only 20% of opioid-dependent people.[23] There are an estimated 600,000 to 800,000 untreated opioid-dependent patients in the US.[24] Primary health care services are not universally available as they are in Britain and Australasia and most patients who do receive MMT obtain it from an outpatient specialist service, only a minority of which provide any primary health care.[25] To address the fragmentation of care, improved integration and communication between specialist drug services and health care providers is called for.[26] Commentators in the US also recognise the value of MMT being provided by trained primary health care doctors, with destigmatisation, normalisation, enhancement of patient privacy and integration of health care provision.[27]

A randomised controlled trial of stabilised MMT patients in the US attending either a narcotic treatment programme or a trained primary health care physician found that transfer to primary health care did not negatively affect illicit drug use or other measures of functional status of the patients.[23] Practitioners indicated that an initial eight hours of training was adequate in preparing them to treat MMT patients, although they also supported the value of ongoing on-site audits and feedback on their clinical practice to improve their quality of care.[28]

In the US, the potential conflict between the traditional emphasis of continuity of care in primary health care with the model of limit-setting and behavioural consequences in substance abuse treatment centres has been identified. Regular communication between primary and secondary service carers are seen as important to address this difference in treatment paradigms.[29]

From this review of the literature, the move to involve primary health services for the care of stable MMT patients appears to be gaining momentum internationally. However, in the UK primary health care has been the norm for decades. In NZ, care of opioid-dependent patients was transferred from GPs to secondary specialist services when these where established, and the recent move is towards returning patients stabilised on MMT back to primary health care with secondary care support when needed. However GPs have no real prescribing independence under an ‘authorised’ scheme and as such true ‘shared care’ does not currently exist in NZ.

Hypothesis

That barriers exist for Auckland Methadone Service (AMS) clients transferring from secondary to primary health care for MMT.

Aim

The aim of this study was to explore the barriers and incentives for the transfer of opioid-dependent people from secondary to primary health care for MMT in the greater Auckland region.

Objectives

To identify the perceived barriers to, and incentives for, opioid-dependent patients on MMT with regards to moving from secondary to primary health care. Specifically perceptions were sought from:

1. AMS clients on MMT deemed stable for transfer by their case managers
2. AMS specialist staff
3. Patients on MMT from authorised GPs in the Auckland region
4. Auckland GPs authorised to prescribe MMT to patients.

Methodology

The project was conducted by the Goodfellow Unit (GFU), Department of General Practice and Primary Health Care, School of Population Health, Faculty of Medical and Health Sciences, The University of Auckland and the AMS, Waitemata DHB.

Setting

Undertaken in the Auckland region covered by the Community Alcohol and Other Drugs Service (CADS).

Consultation and ethics

Support for the project and feedback on the client questionnaires was provided by Sheridan Pooley, CADS Regional Consumer Advisor and Michelle Pike, AMS Consumer Liaison.

Consultation was undertaken with Jane West, Research Advisor, Maori Research Advisory Group (Nga Kai Taataki), Waitemata DHB, who reviewed the research proposal, ethics application, participant questionnaires and participant information sheets.

Approval to conduct the research was obtained from the Waitemata DHB. Ethics approval was obtained from the Auckland Regional Ethics Committee (Reference AKY/04/12/337).

Participants

There were four groups of participants:

1. Auckland Methadone Service (AMS) clients on MMT deemed stable for transfer to primary health care
2. AMS specialist staff (all case managers; medical officers; stabilisation nurses; manager, clinical team leader, psychologist and GP liaison co-ordinator)
3. GP patients on MMT
4. GPs authorised to prescribe MMT by the AMS.

AMS clients deemed stable to transfer according to service indicators of stability (see *Appendix E*) were identified by their case managers. AMS specialist staff were identified by the stabilisation nurse, who was nominated by the AMS Manager to be part of the research team. AMS estimated the number of MMT patients attending Auckland GPs to be 274. An AMS GP liaison co-ordinator provided the list of authorised GPs sourced from the CADS database. Participant Information Sheets (PIS) were provided for participants of each of the four groups (see *Appendix A*). For questionnaires for each participant group see *Appendix B*.

Questionnaire development

Questionnaires were developed using existing knowledge on issues such as barriers to secondary to primary health care transfer identified from the literature in conjunction with input and feedback from researchers and consultants. This spanned a wide range of perspectives including specialist service staff, general practice, pharmacy, primary health care education, consumers and M ori. Questionnaires were piloted on AMS staff, GPs and consumers who were ineligible to be study participants. Changes were made to questionnaires in response to pilot feedback.

Participant recruitment and data collection

AMS staff as identified above were informed about the project by the manager and were recruited via the stabilisation nurse who distributed the specialist staff questionnaires. AMS staff with client caseloads were asked to recruit clients whom they deemed stable for transfer to primary health care whom they saw over the next three months. These staff were provided with AMS client PISs and questionnaires. They were asked to complete a distribution form on which they logged client attendance and consideration to participate in the study (see *Appendix C*). At the end of the study the AMS staff returned these logs to the researcher with the client names removed to preserve anonymity.

The GPs were recruited by an initial letter from the principal investigator containing an explanation of the study, a GP PIS and a questionnaire, plus a freepost envelope for its return. This letter also included recruitment packages for the number of MMT patients that AMS had identified were under each GP's care. GPs were requested to distribute these packs to their MMT patients. GPs were also provided with a distribution form on which they were to log their MMT patients similar to that provided to AMS case managers (see *Appendix C*). This was returned anonymised in a freepost envelope to the researchers at the end of the study. The GPs were sent a reminder fax informing them how to obtain more patient questionnaire packs should they require them, and a final letter encouraging them to return their own questionnaires even if they did not currently have MMT patients under their care.

All participants were provided with freepost envelopes in which to return their anonymous questionnaires. In order to ensure anonymity, specialist staff were asked to identify themselves as either case managers or 'other' staff members.

GPs were offered a book voucher to participate in recognition that involvement in research impinges on their private practice costs. To identify participating GPs, their questionnaires were numbered. These numbers were then removed from the returned questionnaires to be matched with the list of GPs prior to the researcher receiving the completed questionnaires.

Data analysis

The questionnaires included both quantitative and qualitative (free text) data. A triangulated multimethod approach was undertaken for data analysis.

Quantitative data were numerically coded and entered into an Excel spreadsheet. Statistical analysis was conducted by importing the data into the SPSS statistical package (Version 12).

Free-form data response analysis used a general inductive approach with individual text responses initially analysed to identify sub-themes. The data were collated into table form and analysed for emerging categories. These were combined into major themes through ongoing discussion and reading of the data by three of the researchers. A theme coding sheet was produced. The same codes were used for the four different participant groups where applicable. The data were independently coded by four of the researchers as a consistency check with discrepancies resolved by adjudication.

Ethnicity coding used the Statistics New Zealand priority recording system, whereby people who responded as both M ori and Pakeha were coded as M ori.[30]

Results

AMS Clients

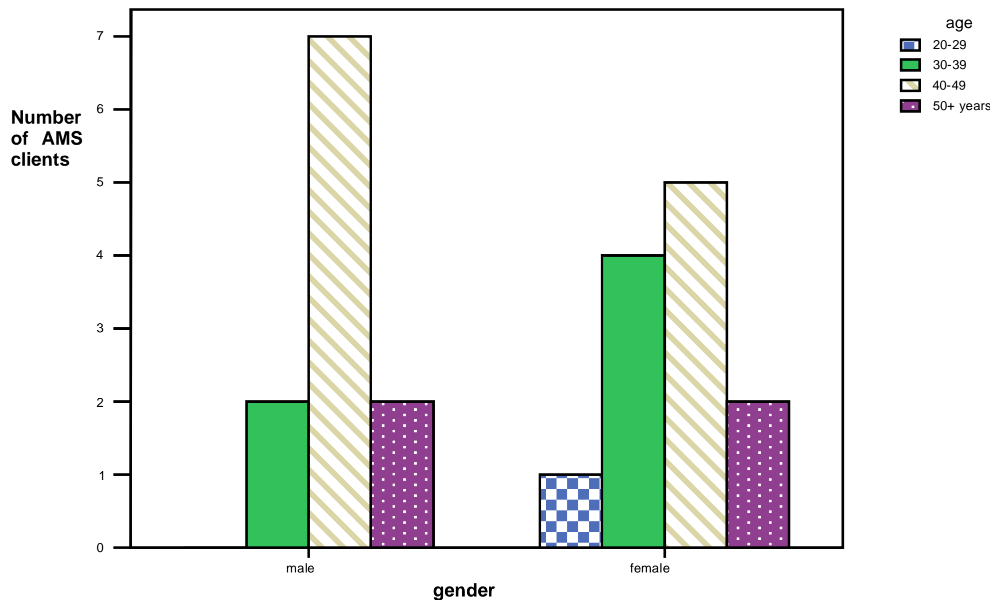
<u>Description of AMS client sample</u>

At the start of the study AMS estimated that they had approximately 95-100 stable clients ready to transfer. The 17 AMS staff with a caseload were asked to identify their stable clients on the provided form and record when they distributed questionnaires to their clients. At the end of the study ten staff members returned these forms. These ten staff had identified a total of 57 stable clients between them. Seven staff members did not return their forms. In some cases this was because they had left the employment of AMS before the completion of the study. Of the 57 identified stable clients, 47 had been given questionnaires to complete. The remaining ten had either declined to participate or had not presented to the staff member during the study period. A total of 23 clients returned the completed questionnaires. Because of the anonymity of responses it is not possible to know the total number of stable clients nor the total number of questionnaires distributed, hence a response rate for this group cannot be calculated.

The AMS client sample was 48% (11/23) male and 52% (12/23) female with ethnicity predominantly European / Pakeha 83% (19/23). The remaining four clients identified as M ori. Most (78%) were aged between 30 and 49.

Figure 1 displays the spread of ages across male and female respondents.

Figure 1: Age and gender of AMS clients



The mean duration that AMS clients had been on MMT was just under seven years (range 16 months to a little over 16 years; SD 4.5 years). Table 1 shows the spread of treatment times for AMS clients.

Table 1: Length of time on MMT (AMS clients)

Length of Time on MMT	Number of Clients (n)
Up to 5 years	9
6 to 10 years	8
11+ years	3
Missing data	3
Total	**23**

The demographics of the AMS client sample were compared with those of the entire MMT client population at AMS in June 2005 (n = 757) and also with a subset of the client database who had been on MMT for at least 16 months (given that all of the study sample had been on MMT for 16 months or more). These are outlined in Table 2. There were no

significant differences with respect to age (the vast majority were aged 30-49 years), ethnicity or gender. While the study sample appeared to be slightly more weighted to females, this was not significant (χ^2=1.32, 1 df; p = 0.3).

Given that the study sample appears to be roughly representative of the total AMS MMT client population, it seems likely that the 23 who returned questionnaires were generally representative of the specialist service clients.

Table 2: Demographics of AMS clients and study sample

		All clients on MMT n = 757 (100%)	>16 months on MMT n = 633 (100%)	Study sample n = 23 (100%)
Gender	Female	311 (41)	255 (40)	12 (52)
	Male	446 (59)	378 (60)	11 (48)
Ethnicity	European/ Pakeha	573 (76)	484 (76)	19 (83)
	M ori	91 (12)	68 (11)	4 (17)
	Pacific Island	12 (2)	11 (2)	0
	Asian	11 (1)	10 (2)	0
	Other	47 (6)	40 (6)	0
	Not stated	23 (3)	20 (3)	0
Age	<20 yrs	2 (0)	1 (0)	0
	20-29 yrs	93 (12)	75 (12)	1 (4)
	30-39 yrs	287 (38)	236 (37)	6 (26)
	40-49 yrs	320 (42)	273 (43)	12 (52)
	50+ yrs	55 (7)	48 (8)	4 (17)
	30-49 years	607 (80)	509 (80)	18 (78)

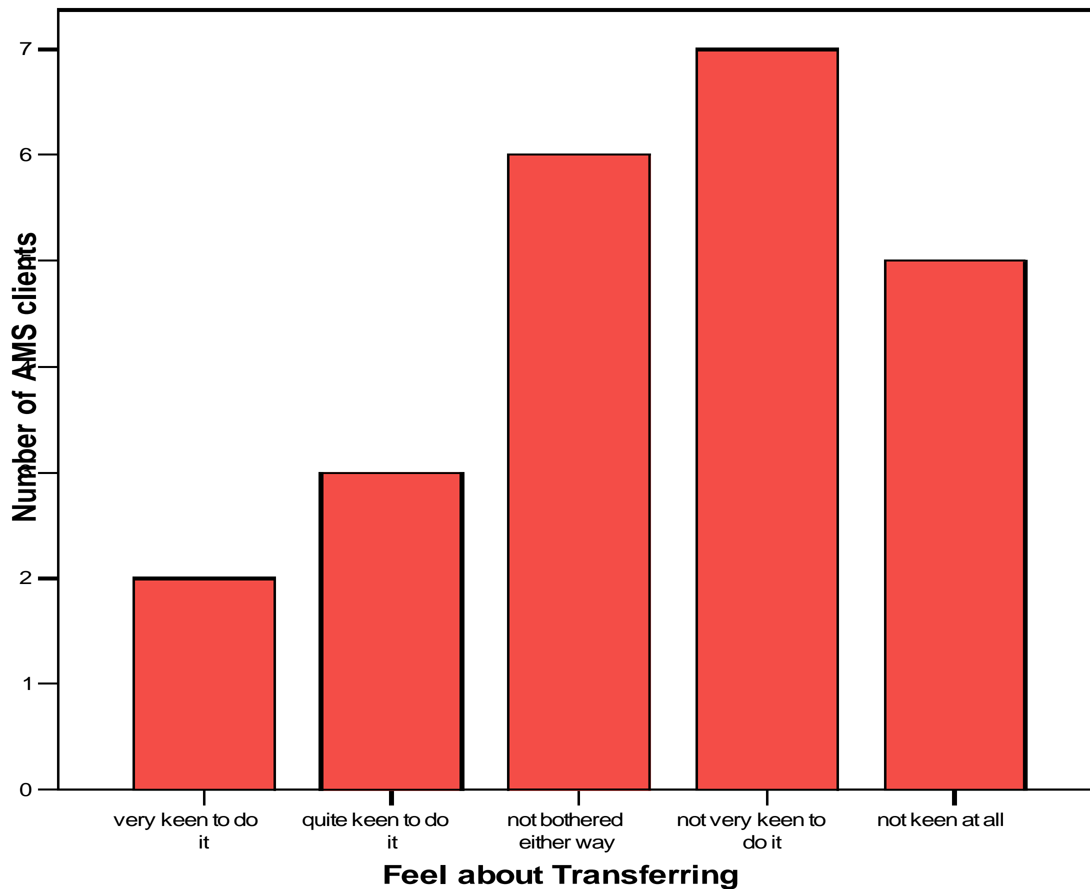
Of those who responded to the survey, over three quarters 78% (18/23) stated that they currently had a GP. Just under one third 30% (7/23) had previously attended a GP for MMT.

Attitudes of clients towards transferring

AMS clients were asked *'Is your manager encouraging you to transfer to a GP?'.* Almost one third of those who answered this question 32% (7/22) stated that their case manager was not encouraging them to do this.

They were also asked *'How do you feel about transferring to a GP?'.* Figure 2 shows that over half the sample 52% (12/23) were 'not very keen' or 'not keen at all' to transfer. Only two respondents were 'very keen to do it'. While the sample size is small, it is interesting to note that none of the seven who responded that they were 'not very keen to do it' had previously attended a GP for MMT.

Figure 2: AMS clients' attitudes towards transferring to a GP



Barriers for clients to transfer

The survey sought to establish the barriers for AMS clients transferring to a GP for their MMT. They were asked to indicate whether a range of reasons were a small barrier, a very large barrier, or not a barrier at all, as outlined in Table 3.

Table 3: AMS clients' barriers for transferring

Statements	*Not a barrier at all* n (%)	*A small barrier* n (%)	*Very large barrier* n (%)
I have had poor service/treatment from GPs in the past	9 (39)	10 (44)	2 (9)
I cannot get a GP in my local area	18 (78)	2 (9)	1 (4)
I cannot afford to go to the GP	7 (30)	8 (35)	7 (30)
I have unpaid fees at my GP	15 (65)	1 (4)	4 (17)
I am worried that the GP might pass on information about my drug use to other people (e.g. family members, employees)	10 (44)	7 (30)	4 (17)
I do not want my GP to be involved in my methadone treatment.	10 (44)	5 (22)	7 (30)
It's a hassle to transfer	13 (57)	5 (22)	4 (17)

Note: Does not add up to 100% due to missing responses

The key reasons chosen for not transferring were financial and not wanting their GP to be involved in their MMT. Cost was identified as a barrier by 65% (15/23) and not wanting GP involvement by 52% (12/23) with seven respondents in both these groups stating that it was a very large barrier. Furthermore, 48% (11/23) individuals identified concerns about confidentiality as a barrier to transferring.

Less significant barriers were local access to a GP, having unpaid GP fees and the 'hassle to transfer'.

Client attitudes towards receiving GP care

AMS clients' attitudes towards receiving MMT from a GP were explored, with survey respondents required to signal whether they strongly agreed, agreed a little, neither agreed nor disagreed, disagreed a little, or strongly disagreed with a range of statements, as outlined in Table 4.

Table 4: AMS clients' attitudes towards GP care

Statements	***Strongly agree n (%)***	***Agree n (%)***	***Neither agree nor disagree n (%)***	***Disagree n (%)***	***Strongly disagree n (%)***
A GP would not provide as good a service as the methadone clinic I currently attend	6 (26)	7 (30)	3 (13)	4 (17)	0 (0)
I would like to deal with one person for all my health needs	5 (22)	6 (26)	4 (17)	6 (26)	0 (0)
I am worried that a GP might have a negative attitude towards drug users	5 (22)	9 (39)	3 (13)	0 (0)	4 (17)
There is less stigma attending a GP than attending the methadone service	1 (4)	2 (9)	9 (39)	5 (22)	4 (17)
I do not expect a GP to be as knowledgeable about drugs as my case manager	10 (44)	9 (39)	1 (4)	0 (0)	1 (4)
I feel safer attending the methadone service	5 (22)	9 (39)	6 (26)	1 (4)	1 (4)
I would miss my relationship with my case manager	8 (35)	7 (30)	4 (17)	2 (9)	0 (0)

Note: Does not add up to 100% due to missing responses

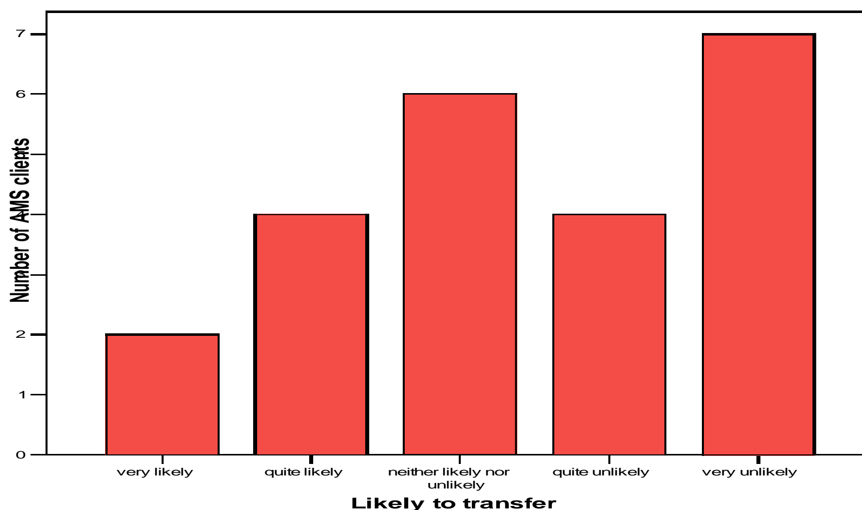
These findings reveal some negative views of GP care, with a vast majority 83% (19/23) of AMS clients agreeing or strongly agreeing that they did not expect a GP to be as knowledgeable as their case manager. Furthermore, 61% (14/23) of clients either agreed or strongly agreed that GPs might have negative attitudes to drug users, and 56% (13/23) agreed or strongly agreed that a GP would not provide as good a service. A little under two

thirds of the sample 61% (14/23) either agreed or agreed strongly that they felt safer attending the methadone service, and 65% (15/23) would miss the relationship with their case manager. Views were slightly more divided in relation to whether there was less stigma attending a GP service, with the same number (nine) both disagreeing, and neither agreeing/nor disagreeing with this statement.

<u>Client likelihood of transferring</u>

The research sought to establish the likelihood of AMS clients transferring to a GP for MMT in the next six months. Figure 3 shows that nearly half the sample 48% (11/23) reported that this was unlikely to happen within the next six months, with over half of this group (seven) stating that it was 'very unlikely'. Just over a quarter of respondents were less sure with six selecting 'neither likely nor unlikely'. Only two AMS clients (9%) predicted that it was 'very likely' that they would transfer in the next six months.

Figure 3: AMS clients' likelihood of transferring to a GP in the next six months



Client views on proposed interventions

The views of each respondent group were sought on the ‘helpfulness’ of a range of interventions to assist clients when they transfer to GP care (Table 5).

Table 5: AMS clients’ views of proposed interventions

Proposed Interventions	***Not at all helpful*** ***n (%)***	***Quite helpful*** ***n (%)***	***Very helpful*** ***n (%)***
Information sheets or a handbook detailing what the transfer would involve	6 (26)	9 (39)	6 (26)
A video showing what it is like to transfer	10 (44)	9 (39)	2 (9)
A short education session	10 (44)	8 (35)	1 (4)
Talking to others who had already transferred	8 (35)	9 (39)	3 (13)
Having somebody (from Auckland Methadone Service) accompany you on your first visit to the GP	11 (48)	3 (13)	6 (26)
Knowing you could try it out, and return to the specialist methadone service if you wished	3 (13)	4 (17)	13 (57)

Note: Does not add up to 100% due to missing responses

AMS clients were most positive about knowing that they could try it out and return to the specialist service, with 57% (13/23) rating this as ‘very helpful’ and a further four ranking it as ‘quite helpful’. Information sheets/ handbook were also considered very helpful by a quarter of the sample 26% (6/23). Talking to others was felt to be very helpful by 13% (3/23).

Interventions which were considered not particularly helpful were the video and short education session, with nearly half 44% (10/23) rating both of these as ‘not at all helpful’. Views were mixed with respect to AMS staff accompanying clients on their first visit, with 48% (11/23) of the opinion that this was ‘not at all helpful’, compared with 39% (9/23) rating it as either ‘quite helpful’ or ‘very helpful’.

Thematic analysis of qualitative data from clients

AMS clients were asked '*What other reasons have stopped you transferring to a GP for your methadone maintenance treatment?'*. Examples of emergent themes are shown in Table 6 below, and the complete dataset of responses is in *Appendix D: 1. Thematic analysis – AMS clients*.

Table 6: Other reasons for clients not transferring to a GP

Theme	AMS client response
GP service lower standard	'*I worry the understanding of drug addiction with GPs .. come with a lot more preconceived notions and stereotypes. Some think because you're on a stable dose you are stoned all the time and won't treat pain as seriously.'*
Increased stigmatisation	*'I was made to feel like a scumbag and a second class citizen for trying to do something about my addiction'*
Less expertise	*'They are very ignorant regards dope fiends'*
Too much responsibility	*'I have a bad memory. Whereas CADS is monthly and they let me know when and where to turn up'*
Client previous negative experience with GP	*'I have already been to a GP for my treatment. It was a disaster, I felt I had no support. I had nothing but drama and I could not wait to be with the programme again'*
Financial	*'I can't afford to pay for visits to doctors to see if I like them'*
	'The only reasons I can think of to the negative would be cost per visit to GP'
Good relationship with specialist service	*I enjoy the contact of having a case manager. I don't have many friends and if I have any hassles they're good to talk to*
Client fear of the unknown	*'I'm not sure about the other doctors as I don't know them'*
Lack of authorised GP	*'I belong to* [name of general practice] *and have been told they don't do methadone'*

The main theme to emerge was concern about their possible relationship with a GP – that they would be stigmatised, not receive as good a service from a GP or have to take increased responsibility for their own care. There were concerns that GPs would not know enough about MMT, and some thought it would be difficult to access an authorised GP. Another prominent theme was satisfaction with the AMS service and the 'status quo'. The cost of attending a GP also featured as a significant barrier.

Some clients felt that a transitional period with shared care between secondary and primary health care would be helpful '*I think that people should still see their case managers for a period of time, like a probation period*'; *'As long as decisions made by the GP are not overridden by methadone service employees, otherwise what is the point (within reason naturally)'.*

AMS specialist staff

Description of AMS staff sample

Thirty AMS staff were identified as potential participants. Four of these were excluded (three were pharmacists and one had left the service). A decision was made at the onset to exclude both community and specialist service pharmacists from the study populations. Eligible staff were 15 case managers; five medical officers; two stabilisation nurses; one manager, one clinical team leader, one psychologist and one GP liaison co-ordinator. Twenty of the 26 eligible AMS staff responded to the survey (77% response rate). All 15 case managers responded. Most 85% (17/20) were staff with a caseload of clients, ranging in size from 10 through to 74. The mean number of clients in a caseload was 41. The remaining three staff respondents were involved in client care but without a specific caseload. The numbers of clients cared for by AMS staff at the time they completed the survey is shown in Table 7.

Specialist staff were also asked to estimate how many of their clients were currently stable according to AMS indicators of stability (See *Appendix E: Indicators of MMT stability / instability*). The median number of clients identified as stable was 19 (range zero to 41).

Table 7: Number of clients per staff member with a caseload

Number of Clients	Number of Staff (n)
10 – 20	5
21 – 30	0
31 – 40	2
41 – 50	4
51 – 60	4
61 – 70	1
71 – 80	1
not applicable	*3*
Total	**20**

AMS staff views on the transfer process

The specialist staff survey sought AMS staff views on the transfer process, their experiences in encouraging clients to transfer, and what they believed the barriers were for clients moving from secondary to primary health care (Table 8).

The vast majority of staff indicated support for the transfer process from specialist to GP care, with 80% (16/20) agreeing that they were generally supportive, and a further 60% (12/20) agreeing that there are some advantages for clients to receiving MMT from a GP. However, nearly half of the staff with a caseload 40% (7/17) indicated that they were not actively encouraging their stable clients to transfer to a GP.

Almost two thirds 65% (13/20) of staff had concerns about GPs' attitudes towards MMT clients. Nearly half 48% (10/21) agreed that some clients get annoyed and/or feel pressured when discussing transfer to a GP and 85% (17/20) agreed that many stable clients show little interest in transferring to a GP. Furthermore, 70% (14/20) believed that there were some clients identified as stable who were not ready to transfer.

Table 8: AMS staff views on the transfer process

Statements	Strongly agree n (%)	Agree a little n (%)	Neither agree nor disagree n (%)	Disagree a little n (%)	Strongly disagree n (%)
I am generally supportive of the transfer of clients from specialist to GP care	10 (50)	6 (30)	4 (20)	0 (0)	0 (0)
I am actively encouraging my stable clients to transfer to a GP	9 (45)	3 (15)	4 (20)	3 (15)	0 (0)
I worry that my clients who transfer to a GP will not receive as good a service as they do at AMS	3 (15)	11 (55)	1 (5)	0 (0)	5 (25)
I have concerns about GPs' attitudes towards clients on MMT	2 (10)	11 (55)	4 (20)	2 (10)	1 (5)
I believe there are advantages for clients to receive their MMT from a GP	8 (40)	4 (20)	5 (25)	3 (15)	0 (0)
Many of my stable clients have shown little interest in transferring to a GP	9 (45)	8 (40)	1 (5)	2 (10)	0 (0)
Some clients get annoyed and/or feel pressured when I talk to them about transferring to a GP	1 (5)	9 (45)	3 (15)	3 (15)	4 (20)
I believe that some clients who have been identified as stable are not ready to transfer	2 (10)	12 (60)	3 (15)	2 (10)	1 (5)
I believe that some clients are ready to transfer but to do not meet AMS indicators of stability	2 (10)	7 (35)	3 (15)	3 (15)	4 (20)
Transferring clients to a GP creates an additional workload in my job (e.g. increased paperwork)	0 (0)	4 (20)	4 (20)	3 (15)	9 (45)

Note: Does not add up to 100% due to missing responses

Findings from the research would suggest that the transfer of clients to a GP does not have a significant impact on the workload, with only four agreeing that transferring clients creates additional workload.

AMS staff views on proposed interventions

AMS staff were asked their opinions on the helpfulness of proposed interventions to assist client transfer (Table 9). The opportunity to return to the specialist service was considered

most helpful amongst AMS staff, with 70% (14/20) rating it very helpful and a further five considering it quite helpful. Staff accompanying clients on their first visit, short education sessions, information sheets/handbook and talking to others who had already transferred were also considered of value. Similarly to clients, a video about transfer was given the lowest rating, with 40% (8/20) staff stating that this was not helpful at all.

Table 9: AMS staff's views of proposed interventions

Proposed Interventions	***Not at all helpful*** ***n (%)***	***Quite helpful*** ***n (%)***	***Very helpful*** ***n (%)***
Information sheets or a handbook detailing what the transfer would involve	0 (0)	14 (70)	6 (30)
Knowing you could try it out, and return to the specialist methadone service if you wished	1 (5)	5 (25)	14 (70)
Having somebody (from AMS) accompany you on your first visit to the GP	2 (10)	4 (20)	12 (60)
A short education session	2 (10)	9 (45)	8 (40)
Talking to others who had already transferred	2 (10)	10 (50)	8 (40)
A video showing what it is like to transfer	8 (40)	7 (35)	5 (25)

Note: Does not add up to 100% due to missing responses

Thematic analysis of qualitative data from AMS staff

AMS staff were asked *'What do you think are the barriers for stable clients who do not transfer to a GP?'*. Examples of emergent themes are shown in Table 10, and the complete dataset of responses is in *Appendix D: 2. Thematic analysis – AMS staff.*

As with AMS clients, the major theme to emerge was that clients were likely to get an inferior service from a GP, with concerns around confidentiality, stigmatism, *'the GP does not have sufficient knowledge/experience in MMT'*; that GPs are too lenient; that the clients would lose the one-to-one personal care and that going to a GP puts too much responsibility onto the client (regarding making appointments and getting their

prescriptions). Some commented that clients had previous bad experiences with GPs. A number of staff felt that clients were getting a good service with AMS, and that clients had anxiety about losing the relationship with their case managers. The cost of attending a GP was seen as a significant barrier by AMS staff, and several were concerned that it would be difficult for their clients to find an authorised GP.

Table 10: Other reasons for AMS clients not transferring to a GP

Theme	**Examples of AMS staff responses**
GP service lower standard	*No real advantage in them transferring (except the perception of more takeaways and less interventions. This would appeal to unstable clients)'*
Less confidentiality	*'Confidentiality / insurance issues'*
Increased stigmatisation	*'Being further stigmatised'*
Less expertise	*'GP does not have sufficient knowledge/experience'*
Less continuity of care	*'No personal one-to-one'; 'Loss of continuity'*
Too much responsibility	*'Unable to take responsibility for scripts, consultations etc'*
Client previous negative experience with GP	*'Bad experiences with GPs in past'*
Good relationship with specialist service	*'If it ain't broke don't fix it' '[Clients] prefer specialised input'*
Client fear of the unknown	*'Client anxiety about transfer'; 'Fear of abandonment'*
Lack of authorised GP	*'Finding a suitable GP, who is willing and able to prescribe'*
Financial	*'Cost of GP fees'; 'Previous bad debts – doctor shopping etc.'*

The survey also asked for staff views on any other ideas/incentives that might encourage clients to transfer to a GP (Table 11).

Table 11: Other ideas/incentives that might encourage clients to transfer to a GP

Theme	Example of AMS staff responses
Financial	*'Free prescription charges up to 3 items on other prescribed medications."*
(modification of current funding system)	*'An allowance over and above community services card'*
	'PHOs should subsidise GP methadone visits'
Shared care approach / transition period	*'Should be made an inbuilt part of the pathway to move clients to the GP programme. Should be part of the system when they first come in for stabilising' 'Shared care – i.e. transition period where case manager and GP co-manage client (e.g. for 6 months)',*
AMS support for initial GP visits	*'Formal introduction to practice nurse'*
Education of clients	*'If the clients could somehow be sure that the GP was friendly and wanted to be involved in their care. Perhaps a pamphlet with a statement from various GPs outlining client-centred approach'*

One staff member was unsupportive of the need for transfer: *'I would question the seeming automatic assumption that the best place for stable clients is MMT with a GP. There is a strong argument that a client is supported in their stability by worthwhile and wholesome case manager and medical officer intervention*'.

Financial assistance for clients attending GPs was a frequent suggestion. A more formalised transition period with client support was also a common theme, with possible introduction to the GP practice by AMS staff. Ensuring clients knew that the GP would provide them with good friendly care was also identified.

GP patients

Description of GP patient sample

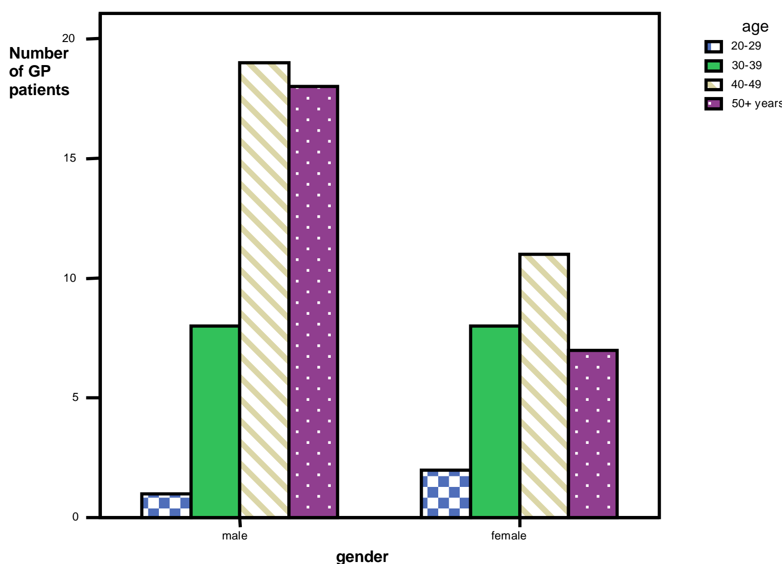
AMS estimated that there were 274 stabilised MMT patients attending 108 authorised GPs. However, actual numbers of patients under individual GP care were both under and over-estimated by AMS. For example, one GP thought to have 21 MMT patients by the service actually had 18, whereas another thought to have one actually had six.

Forty-two of the 77 GP respondents returned their distribution log forms. These indicated that they had distributed 134 questionnaires between them to MMT patients. A total of 74 GP patients returned completed questionnaires. These may include patients both from GPs who returned their distribution log forms and those who did not. Because it is not possible to ascertain whether all these patients attended the 42 GPs who returned the distribution forms, it is unknown how many GP patients in total received questionnaires.

As with AMS clients, GP patients were predominantly European / Pakeha 78% (58/74), with 16% (12/74) identifying as M ori, and 1% (1/74) each in the Pacific and Asian categories. This was not significantly different from the ethnic makeup and gender balance of the total AMS client population.

However GP patients on average were significantly older than AMS clients, with 63% (46/74) aged 30-49 years (compared with 78-80% clients on the AMS database; χ^2 8.6, df 1, *p*=0.003) and around a third 34% (25/74) aged over 50 years. Just under three quarters 74% (55/74) of the sample were aged 40 years and over (see Figure 4).

Figure 4: Age and gender of GP patients



The length of time that GP patients had been on MMT varied considerably, and ranged from 2-30 years (see Table 12). The average length of time receiving treatment was 11 years. Around one third 34% (25/74) of the sample had been receiving MMT for 11 or more years, with almost half 45% (33/74) in the 6-10 year category.

Table 12: Length of time on MMT (GP patients)

Length of time on MMT	Number of patients n (%)
Up to 5 years	13 (18)
6 to 10 years	33 (44)
11+ years	25 (34)
Missing data	3 (4)
Total	**74 (100)**

Around two thirds 68% (50/74) of the sample had been attending a GP for MMT for more than three years. Only six patients (8%) had started going to a GP for MMT in the last year.

GP patients' reasons for transferring

The survey included questions about GP patients' rationale for transferring to GP care. Respondents were presented with a list of reasons (see Table 13) and required to indicate whether it was 'the main reason', 'part of the reason' or 'not a reason at all' for transferring.

Findings reveal that a desire to deal with one person for all their healthcare needs was the main motivation for MMT patients transferring to GP care 81% (60/74) of the sample indicated that this was 'part of' or 'the main' reason). In addition, nearly two thirds 64% (47/74) signalled that freeing up a space for someone else on the waiting list was behind their reason for transferring, with 60% (44/74) citing a wish to move from a specialist service into a more mainstream health service.

By comparison, the ability to access after-hours appointments and a GP closer to home were less motivating factors, although these were still rated as either 'part of' or 'the main reason' by 32% and 51% of the sample respectively. Dissatisfaction with the specialist service was behind the move for a little over a third (35%) of GP patients. Only 9% indicated that they transferred because they thought they would get more methadone takeaways.

Table 13: GP patients' reasons for transferring

Statements	***Not a reason at all*** **n (%)**	***Part of the reason*** **n (%)**	***The main reason*** **N (%)**
I wanted to free up a space for someone on the methadone maintenance treatment list	23 (31)	36 (49)	11 (15)
I wanted to deal with one person for all my health needs	6 (8)	28 (38)	32 (43)
I wanted to be able to access after-hours appointments	36 (49)	18 (24)	6 (8)
I wasn't happy with the service I was receiving at the methadone service	36 (49)	17 (23)	9 (12)
I wanted to move away from a specialist drugs service, into a more mainstream health service	24 (32)	27 (37)	17 (23)
I thought I would get more takeaways	55 (74)	6 (8)	1 (1)
The GP is closer to where I live	28 (38)	23 (31)	15 (20)

Note: Does not add up to 100% due to missing responses

<u>Patient perceptions and experiences of GP care</u>

Questions relating to GP care required respondents to indicate whether they 'strongly agreed', 'agreed', 'neither agreed nor disagreed', 'disagreed', or 'strongly disagreed' with a range of statements.

Table 14 illustrates that only a fifth of the sample felt pressured to transfer to a GP. Only a minority indicated that they had had concerns about a GP not providing as good a service as the specialist service (17%), and GP attitudes towards drug users (28%). The majority of respondents either agreed or strongly agreed that there is less stigma attending a GP (76%) and that they are able to get GP appointments at more suitable times (82%). By comparison, less than a third (28%) agreed that they have more rights as a GP client (due to paying for the service), with 42% indicating that they neither agreed nor disagreed with this statement.

Table 14: GP patients' perceptions and experiences of GP care

Statements	*Strongly Agree n (%)*	*Agree n (%)*	*Neither agree nor disagree n (%)*	*Disagree n (%)*	*Strongly Disagree n (%)*
There is less stigma attending a GP than being a client of the methadone service	27 (37)	29 (39)	10 (14)	2 (3)	3 (4)
I felt pressured to transfer to a GP	3 (4)	12 (16)	8 (11)	26 (35)	20 (27)
I have more rights as a GP client as I am paying for the service	10 (14)	10 (14)	31 (42)	12 (16)	5 (7)
Before transferring, I was worried that a GP might not provide as good a service as the methadone service	2 (3)	10 (14)	16 (22)	26 (35)	16 (22)
Before transferring, I was worried that a GP might have a negative attitude towards drug users	4 (5)	17 (23)	12 (16)	23 (31)	13 (18)
I am able to get appointments at the GP at times that suit me	26 (35)	35 (47)	8 (11)	1 (1)	1 (1)

Note: Does not add up to 100% due to missing responses

GP and specialist service comparison by patients

Respondents were asked whether seeing a GP for their methadone treatment was better, worse, or neither better nor worse than attending a specialist service. Nearly three quarters 73% (54/74) rated GP care as better, and no patients stated that it was worse than attending a specialist service. In line with this, 81% (60/74) of GP patients stated that

it was very unlikely that they would transfer back to the methadone service in the next six months. There were no respondents who stated that it was either ‘quite likely’ or ‘very likely’ that they would transfer.

GP patients’ views on proposed interventions

The views of GP patients were sought on the ‘helpfulness’ of a range of interventions to assist clients when they transfer to GP care (Table 15).

Table 15: GP patients’ views of proposed interventions

Proposed Interventions	***Not at all helpful*** ***n (%)***	***Quite helpful*** ***n (%)***	***Very helpful*** ***n (%)***
Information sheets or a handbook detailing what the transfer would involve	4 (5)	38 (51)	24 (34)
Knowing you could try it out, and return to the specialist methadone service if you wished	11 (15)	26 (35)	26 (35)
Talking to others who had already transferred	12 (16)	28 (38)	22 (30)
Having somebody (from Auckland Methadone Service) accompany you on your first visit to the GP	23 (31)	25 (34)	15 (20)
A short education session	26 (35)	24 (32)	11 (15)
A video showing what it is like to transfer	34 (46)	22 (30)	8 (11)

Note: Does not add up to 100% due to missing responses

The offer of information sheets/ handbook was the most appealing to this group and the opportunity to talk to others who have already transferred and the ability to return to the specialist service were also well received. Less popular were the video and the short education session. Having somebody accompany them on their first visit was considered helpful by just over half of GP patients.

Thematic analysis of qualitative data from GP patients

GP patients were asked '*Are there any other reasons why you transferred to GP care?'* Examples of emergent themes are shown in Table 16, and the complete dataset of responses is in *Appendix D: 3. Thematic analysis – GP patients*.

Table 16: GP patients' reasons for transferring to GP care

Theme	Examples of GP patient responses
GP service better standard	*'I have complete trust in him. I feel I can confide in him if any problems may arise.'*
More confidentiality	*'It's possible to meld with everybody at the surgery because you're not by your presence a 'low life abuser', which is just one of several worthy reasons'*
Less stigmatisation	*Overall GP service is just BETTER. I feel like a person whose life and opinion mean something, not just treated like a druggie who's only looking to score'*
More expertise	'*No pressures come from the doctor, but the ability to talk of dosage change (up or down) or even illicit drug use without fear of unannounced responses is a major relief'*
More continuity of care	*'Better to have to tolerate the arbitrary decision making of one person, rather than those of a collection of 'odds and sods', i.e. CADS'*
More responsibility	*'Just for more independence and control over my own life decisions'*
Holistic care	*'To integrate the treatment of my drug related health issue with my overall health care'*
Dissatisfaction with specialist service	*'I seemed to be treated as a 'criminal' when I was attempting to improve my life. I needed rewards, not restrictions as I did the programme properly'*
Able to avoid other opioid-dependent people	*'I wanted to break away from association or bumping into drug addicts, associates etc. I need anonymity. GP scheme for me has been a step forward'*
GP more convenient / flexible / accessible	*'Doctors always available'; "Closer to home'; 'Easier to make appointments'; 'No transport problems'*
Free up specialist place for other people	*'I think people should not be so selfish about not going on GP thing, cos it frees up people waiting to go on'*
Financial	*'Clinic was also far away but didn't make me pay for appointments. Balances out I guess"* '*Fantastic service although more costly'*

GP patients provided considerable detail in their free text responses. The strongest theme to emerge was improvement in the quality of their care, and appreciation of the GP/patient relationship. Attending the GP was considered more confidential, less stigmatising, more normalising and gave them better control over their own treatment. Patients liked attending one person for all their health care needs. A number expressed dissatisfaction with their previous experiences of the specialist service.

For some GP patients, they (wrongly) believed that by moving on to a GP they freed up a place at the specialist service for a new client to obtain treatment.

Many GP patients were concerned about the cost of GP visits, although for others savings from reduced travelling and time off work balanced out the price of GP fees. GP patients were asked their reasons for stating that GP care was 'better', 'worse', or 'neither better nor worse' (Table 17). Given that 73% felt that primary was better than secondary care, most comments emphasised the advantages of attending a GP.

Some GP patients felt that AMS clients should receive more information about the benefits of transfer *('CADS patients need to be made aware that moving to a GP programme is a 'POSITIVE STEP' towards moving on in life – AS I DID'*) although it was important that the GP be trained and knowledgeable about MMT (*'Doctors need to have proper training though, I know mine did'*).

Table 17: Reasons for stating GP care was 'better', 'worse', or 'neither better nor worse'

Theme	Examples of GP patient response
Financial (cost is a barrier)	*'I've found that the expense is huge being on a GP scheme, but it was something I was willing to make allowances and sacrifices for so I could afford to attend a GP.'*
(cost is incentive)	*'Being closer to home will save gas money and will be easier on my [disability]'*
One person for all healthcare needs	*'Feel it is logical to see my GP as I can monitor my overall health'*
Good relationship with GP	*'My GP knows the methadone treatment plans and policies, plus my personal circumstances. He treats my personal needs and I'm not treated like a sheep'*
Continuity of care (GP service)	*'Only see one doctor, not many different ones. Only have to tell one person your 'life story', not many (as caseworkers seem to change almost MONTHLY)'*
GP service more flexible	*'GP takes a commonsense approach and is prepared to be flexible'*
GP service more convenient	*'It is much better for me because I work and I can get to see my GP after my work hours because he does not close until 6 o'clock. With the methadone service I was always having to take time off work, which almost cost me my job. GP is much better for the working man, woman'*
Able to avoid other drug users / drug using scene	*'Not having to go to one place to pick up with everyone else on the programme. There is much less chance of me re-meeting old acquaintances going to my own GP'*
Good relationship with specialist service	*'The years spent attending the clinic were very helpful and there was always excellent support for me'*
Dissatisfaction with specialist service	*'A very few minor things happen differently within a GP service. For starters there is no oppressive, negative attitudes from overworked, underappreciated methadone staff.'*
Free up space on MMT waiting list	*'My reason was to get somebody deserving onto the programme as I know what it's like to scavenge out on the streets'*
GP service confidential	*'My GP is marvellous. I can tell him anything and know it won't be discussed by a 'team'!'*
Greater control over treatment	*'I feel more in control rather than controlled'*
More takeaways with GP service	*'Because I built trust with my GP I also had increased takeaways which made my career goals easier to achieve and maintain'*

GPs

Description of GP sample

AMS identified 108 authorised GPs. Four of these were ineligible for the study (one had retired; one was practising in the Bay of Plenty outside the study area, and two were authorised but had never had MMT patients to care for). Of the 104 eligible GPs, 77 responded to the questionnaire (74% response rate). At the time of the survey GPs had an

average of three patients each (range 0-20, SD 3.5). Two thirds of responding GPs 66% (51/77) had up to three methadone patients, with less than a tenth 9% (7/77) of the sample with eight or more as illustrated in Table 18.

One of the two excluded GPs who were authorised by the AMS, but who had never cared for any MMT patients made the following comment: *'I agreed to one patient where the family I have been involved with for 20 years. She never showed up'* . This GP was very unwilling to receive a future MMT patient. The other was willing, but had never received any referrals.

Table 18: Number of MMT patients per GP

Number of MMT Patients	n	(%) of GPs
0 to 3	51	(66)
4 to 7	17	(22)
8 to 10	4	(5)
11 +	3	(4)
Missing responses	2	(3)
Total	77	(100)

The respondent GPs had been prescribing methadone under authorisation for a mean of 4 years 3 months (range two months and 13 years; SD 3.3 years). Table 19 shows that two thirds of the respondents had been prescribing MMT for five years or less.

Table19: Length of time prescribing

Length of time prescribing	n	(%) of GPs
Up to 5 years	51	(66)
6 to 10 years	23	(30)
11 + years	1	(1)
Missing responses	2	(3)
Total	77	(100)

GP views of MMT patients and their treatment

The research sought GPs' views of their experience of MMT delivery. Respondents were required to indicate whether they 'strongly agreed', 'agreed a little', 'neither agreed nor disagreed', 'disagreed a little' or 'strongly disagreed with a range of statements (Table 20).

The majority of GPs indicated support for the transfer of MMT patients to primary health care, with 79% (61/77) either agreeing a little or strongly agreeing with this statement. The same proportion also agreed that they felt supported by AMS in dealing with patients on MMT, and confident that patients on MMT received a good service from their practice. Whilst 39% (30/77) disagreed (either a little or strongly) that their appointments with patients on MMT are sometimes rushed, around a third 34% (26/77) neither agreed nor disagreed with this. In addition, a little under half the sample 48% (37/77) disagreed that patients on MMT are no more problematic than other patients.

Table 20: GP views of MMT patients and their treatment

Statements	***Strongly agree n (%)***	***Agree a little n (%)***	***Neither agree nor disagree n (%)***	***Disagree a little n (%)***	***Strongly disagree n (%)***
Patients on MMT are no more problematic than other patients	15 (20)	17 (22)	8 (10)	26 (34)	11 (14)
I feel supported by AMS in dealing with patients on MMT	39 (51)	22 (29)	9 (12)	2 (3)	4 (5)
My appointments with patients on MMT are sometimes rushed	2 (3)	18 (23)	26 (34)	13 (17)	17 (22)
I feel confident that patients on MMT receive a good service from my practice	39 (51)	22 (29)	9 (12)	1 (1)	4 (5)
I support the transfer of patients on MMT from secondary to primary health care	37 (48)	24 (31)	7 (9)	7(9)	2(3)

Note: Does not add up to 100% due to missing responses

Barriers for GPs accepting further patients

The survey explored GPs' reasons for not accepting further patients for MMT. Respondents were asked to rate whether a number of issues were a small barrier, a large barrier, or not a barrier at all (see Table 21).

The main barriers identified were patients being disorganised; problems with prescriptions and unpaid bills. Nearly half considered patients on MMT transferring before stable as being a small barrier to accepting further patients. Around half the GP respondents rated patients on MMT having co-existing disorders or needing longer appointment times than other patients as not being a barrier at all.

Table 21: Barriers to GPs accepting further MMT patients

Statements	*Not a barrier at all* n (%)	*A small barrier* n (%)	*Very large barrier* n (%)
Patients on MMT are often disorganised (e.g. need takeaways at short notice)	10 (13)	52 (68)	15 (20)
Patients on MMT often have co-existing disorders	33 (43)	32 (42)	12 (16)
There can be problems with prescriptions for patients on MMT	21 (27)	44 (57)	11 (14)
Patients on MMT need longer appointment times than my other patients	41 (53)	26 (34)	9 (12)
Patients on MMT often have unpaid bills	17 (22)	31 (40)	26 (34)
Patients on MMT who transfer are not always stable (or what I would define as stable)	30 (39)	36 (47)	8 (10)

Note: Does not add up to 100% due to missing responses

GPs' views of barriers for clients transferring to primary care

GPs views on the barriers for clients transferring were also sought. They were presented with a similar list to AMS clients, and required to indicate how much of a barrier each issue was (Table 22). As with the client sample, GPs highlighted financial issues, with unpaid

fees and not being able to afford to go to the GP were cited as very large barriers. Poor service/treatment from GPs in the past was viewed as a small to large barrier by 78% of the sample. Not being able to get a GP in their local area was viewed as a very large barrier by 42%. Issues rated as ‘a small barrier’ were clients not wanting to leave the specialist service; not wanting their GP involved in their MMT or worrying that their GP might pass on information about their drug use to other people.

Table 22: GPs’ views of barriers to client transfer

Statements	***Not a barrier at all*** **n (%)**	***A small barrier*** **n (%)**	***Very large barrier*** **n(%)**
They have had poor service/treatment from GPs in the past	11 (14)	38 (49)	22 (29)
They cannot get a GP in their local area	15 (20)	29 (38)	32 (42)
They can’t afford to go to the GP	4 (5)	18 (23)	55 (71)
They have unpaid fees at their GP	2 (3)	22 (29)	53 (69)
They are worried that the GP might pass on information about their drug use to other people (e.g. family members, employees)	22 (29)	46 (60)	9 (12)
They don’t want their GP to be involved in tl methadone treatment.	20 (26)	41 (53)	12 (16)
They don’t want to leave the specialist service	20 (26)	37 (48)	17 (22)

Note: Does not add up to 100% due to missing responses

GP willingness to take on more MMT patients

GPs were asked *‘How willing are you to receive further patients on MMT in the next six months?’*. Nearly a third (32%) were either unwilling or very unwilling, 45% indicated they were willing or very willing to do this and the remaining 22% were undecided.

GP views on proposed interventions

As Table 23 illustrates, all the proposed interventions were rated highly by GPs in terms of being quite or very helpful. The offer of information sheets/handbook and the ability to

return to the specialist service were the most appealing to this group. Again, the video was less popular, with a quarter of the sample considering this to be not at all helpful.

Table 23: GP views of proposed interventions

Proposed Interventions	***Not at all helpful*** ***n (%)***	***Quite helpful*** ***n (%)***	***Very helpful*** ***n (%)***
Information sheets or a handbook detailing what the transfer would involve	2 (3)	49 (64)	26 (34)
A video showing what it is like to transfer	19 (25)	42 (55)	15 (20)
A short education session	4 (5)	44 (57)	28 (36)
Talking to others who had already transferred	5 (7)	36 (47)	34 (44)
Having somebody (from Auckland Methadone Service) accompany them on their first visit to the GP	8 (10)	25 (33)	43 (56)
Knowing they could try it out, and return to the specialist methadone service if they wished	2 (3)	23 (30)	51 (66)

Note: Does not add up to 100% due to missing responses

Thematic analysis of qualitative data from GPs

The survey also asked for GPs' views on what else they thought could be done to encourage more patients on MMT to transfer from specialist to primary health care (Table 24). The complete dataset of responses can be found in *Appendix D: 4. Thematic analysis – GPs.*

GPs identified patient costs as a significant barrier and suggested a number of ways that MMT patients might receive financial assistance to attend a GP. One GP was particularly frustrated by the capped funding system which was viewed as a disincentive for AMS clients to transfer or AMS staff to encourage them to do so: *'Frankly I have been concerned that the legislative wish that 50% of patients be under GP care has been subconsciously wasted by the clinics need to retain its patient base to obtain finance (there is no other service in which patients can obtain such care indefinitely free of charge)'.*

GPs advocated transfer as a step-wise process where there was a transitional time of shared care, with *'a review 3-6 months after transfer for reassessment'.* Several suggested development of a contract of care between patient and GP at the onset. A strong theme to emerge was educating patients *'regarding GP services and their commitments with their doctor, practice nurse and chemist'.*

Table 24: GPs' views on what could be done to encourage MMT patients to transfer to GP care

Theme	Examples of GP responses
Financial (cost is a barrier)	*'The problem is not necessarily the patients on MMT as I have several that would like to transfer, but I am unwilling to expand due to the extra time involved and the lack of remuneration as they have high outstanding accounts.'*
Financial (modification of current funding system)	*'To have proper funding for providing services, as I find they are poor payers and require a lot of extra care'; 'Look at other ways of meeting fees, i.e. through [PHO], DHB, government, WINZ'; ''Care plus scheme to encompass MMT patients, with the PHO practitioners 'bulk funded' for them'*
Development of contract of care	*'A brief one page sheet outlining the practical logistics of GP methadone prescribing sent to the GP to sign to say they would be prepared to do this. After it is sent back it should be shown to the patient as evidence the GP is okay with the requirements. Advice re: each individual's GPs 'rules' in the practice (i.e. appointments/payments etc.)'*
Transition period then discharge to GP care	*'Discharge them from AMS with an agreed overall plan/vision of long term (years) treatment. Some patients keen to reduce, others prefer to stay on maintenance. This gives provider (GP) and patient a framework to continue with'*
Education of clients	*'Education about GP being an advocate who won't judge them on reasons why they are on MMT'*
Education of GPs and support staff	*'Better education of primary care doctors on methadone treatment, and better understanding of problems associated. Explain to GPs that all these patients are not a hassle and difficult'*

Some GPs were not keen to have many MMT patients and were deterred by previous negative experiences from MMT patients (*'Stand over tactics and aggression can be very unsettling'*).

Discussion

Summary of findings

The research has revealed some important insights into the barriers and incentives for receiving MMT within a primary health care setting, and highlighted some key differences between the four groups surveyed. It should be noted that some of these are to be expected, given that the AMS client group includes some with previous negative experiences in primary health care, and the GP patient group are likely to include many who have established strong therapeutic relationships with their GP.

Current AMS clients did not show a strong interest in transferring to GP care; over half the sample indicated that they were not keen to transfer, and nearly half predicted that it was unlikely to happen within the next six months. Some of the barriers to transferring reported by clients were expected. Not surprisingly, having to pay for GP appointments acted as a strong deterrent for many clients. Importantly, however, the research has also revealed a level of distrust that clients have towards GPs, and the low expectations they have of the service provided in this setting. Many stated that they did not want their GP to be involved in their MMT and were concerned that their own GP might pass on information about their drug use to other people. Furthermore, they did not expect them to be as knowledgeable as specialist service staff and worried that they would have a negative attitude towards drug users. These views, combined with close and satisfactory relationships with staff in the specialist setting, may be inhibiting the flow of clients from secondary to primary health care. Most of the clients 78% (18/23) said they did have a GP (although not necessarily one authorised to prescribe MMT). This does suggest that attitudinal factors were a major feature in their reluctance to transfer.

It is interesting to contrast these perceptions with the experiences of GP patients. The vast majority rated GP care as better than attending a specialist service, and none felt it was likely that they would transfer back to the methadone service in the next six months.

Of note is the number of comments made by the GP patient group about the close and highly satisfactory relationship they have with their GP and the treatment they receive in this setting. Indeed, many of the concerns highlighted by AMS clients were not borne out by the experiences of this group. GP patients valued the lack of stigmatisation, increased confidentiality and continuity of care they received from their GPs. They liked the GP's holistic approach with MMT 'normalised' and incorporated within their general health care. Whilst the cost of attending a GP was raised as an issue by some respondents, for others local access balanced this cost. Findings from the research would also suggest that dissatisfaction with the specialist service, and a desire for greater control over their treatment was a further driving factor behind some patients' move to GP care. A number of GP patients valued the fact that by not attending the specialist service they could avoid contact with other drug users who might have negative influences on their behaviour.

Authorised GPs who responded to the survey indicated strong support for the transfer of MMT patients from secondary to primary health care. They also signalled that they felt supported by AMS in dealing with patients on MMT. A third expressed a willingness to take on further patients in the next six months, while another third did not. Findings indicate that the potentially disorganised nature of MMT patients, and the difficulties they face in paying bills were key issues impacting on GPs' readiness to extend their MMT client base. This latter issue was further reinforced in the GPs' response to questions regarding incentives to encourage MMT patients to transfer to GP care. Many of the comments received related

to a desire to see the current funding system modified and/or financial assistance provided to MMT patients.

One GP commented specifically on the capped funding system that undermined the policy to move patients from secondary to primary health care. Patients expressed the mistaken belief that by moving on to a GP they freed up a place for another opioid-dependent person to gain specialist treatment. However, because AMS is funded for a total number of clients to be treated regionally (irrespective of whether this care is provided by a primary or secondary service), this is a possible disincentive for staff to encourage stable patients to move to primary health care.

Eighty percent of specialist service staff indicated broad support for the transfer process. This is encouraging, given the influential role that this group plays in supporting clients to transfer. However, 40% of the staff were not actively encouraging their stable clients to transfer, indicating considerable barriers preventing staff to fully endorse this process. Similarly to AMS clients, AMS staff expressed concern about the potentially inferior level of service provided by GPs to MMT patients. Some considered that going to a GP could increase stigmatisation, decrease confidentiality and reduce continuity of care for their clients. One AMS case manager commented that there was *'no real advantage in them transferring'* to a GP.

Staff also expressed concern that patients might become anxious or agitated if they were encouraged to transfer, partly because they felt rejected or that they were being offloaded to an inferior service.

Strengths of the study

One of the strengths of this study was obtaining the simultaneous perspectives on the secondary to primary transfer process from the four main stakeholders: secondary care clients and staff, and primary health care patients and GPs.

The triangulation of quantitative and qualitative data gave an in-depth view on barriers and incentives to the transfer process. The free text provided by the participants gave a rich dataset for analysis.

The high response rates of AMS staff (77%) and GPs (74%) were positive features of the study.

Limitations of the study

One weakness of the study was the relatively low response rates for AMS clients and GP patients and the inability to have an exact denominator for these two groups. The latter was due to the need to maintain participant anonymity and the requirement to use participant AMS staff and GPs to recruit their clients/patients. However, comparison of demographic details of the recruited clients and patients with those of all AMS clients indicate that they are likely to be representative samples with respect to gender and ethnicity.

Respondent group sizes of AMS MMT clients (23) and AMS staff (20) were small.

A few of the questions could have been improved in their wording. There were several occasions where a respondent's answer was ambiguous and therefore that data had to be excluded. In particular, a question to AMS staff as to how much they agreed with the

statement '*I believe that some clients are ready transfer but who do not meet AMS indicators of stability'* was incorrectly worded and interpretation of some replies was unclear.

As mentioned above, the AMS client group included some with previous negative experiences of GPs, and the GP patient group include many who have established good relationships with their GP. Most AMS clients and GP patients who responded were happy with the service they were receiving. This does mean that comparisons between these two groups should be treated with caution.

Key findings

Despite government policy to transfer patients whose dependency condition has been stabilised from secondary to primary health care, and the commitment of considerable resources to train a primary health care workforce (GPs, PNs and community pharmacists) it is apparent that there are significant barriers to client/patient transfer.

A major factor is funding. Funding is an issue which might discourage growth of GP prescribing and client willingness to attend. Secondary care clients receive free treatment, whereas GPs are government-subsidised private practitioners generally requiring a fee for service. This may be a significant disincentive to clients who receive free treatment within the specialist setting. While in theory local protocols may direct that stable clients transfer to a GP, in practice this transfer may be difficult to achieve.

Specialist services operate under a capped funding system to care for a maximum of MMT clients, including both those directly under the care of the specialist service, and those who have transferred to primary health care. If transfer does not free up spaces for new clients

to attend specialist treatment then a capped system is incongruent with a push to transfer to primary health care.

In Auckland, transferred clients have their methadone prescribed by a GP who is authorised by the specialist service. Information is exchanged between secondary and primary health care via GP liaison coordinators. Other regions may not have the resources to support a designated GP liaison coordinator. When patients under GP care de-stabilise, the GP should be supported to re-stabilise the patient. It appears that both AMS clients and GP patients may not be aware that patients under GP care for MMT can return to secondary care or receive specialist assistance if their condition deteriorates. Furthermore, a number of patients erroneously believed that by moving to GP care they made a place available for another untreated opioid-dependent person to receive treatment.

There are varying levels of prescribing responsibility awarded to authorised GPs under a specialist service.[8] *"In some situations, the specialist service … will specify the dose, dispensing frequency or takeaway regime in order to provide guidance and ensure that safety requirements are met. In other situations, only the written authority will be required from the specialist service."* This may lead to difficulties for a GP who is unable to make prescribing decisions without consultation with, or referral back to, the specialist service. This can be problematic in the acute situation.

There is clearly an impression by some of the specialist service staff and their MMT clients that transfer to an authorised GP may result in lower quality or substandard care. For most of the MMT GP patient respondents in this research, however, they were clearly very satisfied with the standard of care provided by their authorised GP.

Another area of concern is a small number of GPs undergoing the training but not receiving referrals from AMS, which is a misuse of both GP time and government resources providing this valuable training.

Recommendations

Specialist services treating opioid-dependent patients should be presented as secondary services from the onset of treatment. This is in line with other secondary care services such as a diabetes clinic, where a patient's management is stabilised and then he or she is discharged back to GP care, with the possibility of review should their condition deteriorate.

MMT clients treated by specialist services should be made aware that the normal expectation is that they will naturally progress from secondary to primary health care as part of their treatment plan. Specialist staff will need to be confident that transferring to an authorised GP is a positive move and an indication of successful management. Feeding back these study results might assist specialist staff to appreciate that transferred clients speak positively about the quality of care they receive from trained authorised GPs. Transfer of clients to primary care frees up specialist staff time to manage more complex cases.

Review and modification of the current funding system was a strong issue for GPs. For some, unpaid bills lead to GPs unwilling to take on more MMT patients. Cost barriers outlined should be explored further to clarify areas for improvement. For example, financial assistance for GP patients; examining the impact of the current specialist service capped numbers for their GP patient funding, additional costs including financial remuneration for GPs to receive education and training and provide services for MMT patients is determined and resourced and associated primary health organisations (PHOs) considerations such as the implications of CarePlus implementation. However, this is not the 'whole answer' as the research has clearly shown that finance is not the sole barrier.

Indeed, when patients experience the benefits of GP care, these may be seen to outweigh the downside of having to pay for the service.

In light of our study findings, we make the following recommendations. These recommendations have been extrapolated from the feedback from the research. However we are aware that some of these recommendations may already be in place within some NZ specialist services.

- That MMT clients are encouraged at the outset to incorporate the progression from secondary to primary health care in their treatment planning.
- That consideration is given to training and upskilling specialist services staff in the transfer process including the reassurance that most GP patients speak positively about the quality of care they receive from trained authorised GPs.
- That specialist services place greater emphasis on providing an integrated transition period for MMT clients transferring from secondary to primary health care including ways of assisting clients to locate authorised GPs in their region and accompanying clients on their first visit.
- That local transfer guidelines be implemented alongside national guidelines for clients, specialists and primary health care staff to support safe, appropriate and best practice transfer from secondary to primary health care.
- That specialist services have systems in place for ongoing consultation with authorised GPs.
- That the identified barrier of specialist service capped funding for MMT clients (specialist service and GP) is reviewed as to whether this is the best way to deliver the service.

- That the options for financial assistance for MMT clients who transfer from secondary to primary health care are explored.
- That specialist services develop processes that support clients to have greater participation in and responsibility for their own treatment and recovery pathway.
- That additional funding including remuneration for GPs to cover administration costs for providing services to their MMT patients is explored and resourced.
- That dissemination of these findings to the Ministry of Health and other key stakeholders may assist review of existing national guidelines, local policies/protocols and training curricula to support best practice transfer.
- That further research is conducted to develop and evaluate the effectiveness of interventions to improve MMT clients transfer from secondary to primary health care.

Appendix A: Participant Information Sheets

1. Participant Information Sheet for AMS clients
2. Participant Information Sheet for AMS staff
3. Participant Information Sheet for GP patients
4. Participant Information Sheet for GPs

Waitemata District Health Board
Te Wai Awhina

THE UNIVERSITY OF AUCKLAND
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PARTICIPANT INFORMATION SHEET FOR AMS CLIENTS

TITLE OF THE PROJECT: Transfer of opioid-dependent people on methadone maintenance treatment to GP care

RESEARCHERS: Dr Felicity Goodyear-Smith, Dr Janie Sheridan, Ms Annette Gohns, Ms Rachael Butler, Ms Amanda Wheeler

You are invited to take part in a collaborative study undertaken by the University of Auckland and Waitemata DHB to explore incentives and barriers in the transfer of clients on methadone maintenance treatment from specialist to primary health care. You are invited to participate because you are a client of Auckland Methadone Service (AMS). We are interested in finding out about your experiences as a client of the methadone service, and your ideas of what it might be like to access treatment from a GP.

If you decide to take part, you will be asked to complete a short questionnaire. This should take less than 10 minutes to complete. A Freepost envelope is provided to return the questionnaire to researchers at the University of Auckland. You can either give this to your case manager to send for you, or post it yourself. If you choose to take this away with you please can you complete and post it within two weeks.

Your involvement is entirely voluntary and completely anonymous. The results of the research will be written up as general themes and issues, with no individual responses identified. No members of staff at the AMS will see your responses. Your decision to participate or not will not influence your treatment in any way.

The knowledge gained from this research will help us understand the needs of clients on methadone maintenance treatment and their views of transferring to GP care. If you are interested, a summary of the research findings will be made available through the AMS at the end of the study.

For research information contact Dr Felicity Goodyear-Smith at 373 7599 Ext 82357, Department of General Practice and Primary Health Care, School of Population Health, University of Auckland, f.goodyear-smith@auckland.ac.nz or you may wish to contact Michelle or Sheridan at the Community Alcohol and Drug Service (CADs) methadone consumer team, Tel 815 5830.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact the Health Advocates Trust Tel 0800 555 050 Northland to Franklin.

This study has received ethical approval from the Auckland Ethics Committee
PIS Version AMS CT #2 16/12/04 Reference AKY/04/12/337

Waitemata
District Health Board
Te Wai Awhina

THE UNIVERSITY OF AUCKLAND
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PARTICIPANT INFORMATION SHEET FOR AMS SPECIALIST STAFF

TITLE OF THE PROJECT: Transfer of opioid-dependent people on methadone maintenance treatment to GP care

RESEARCHERS: Dr Felicity Goodyear-Smith, Dr Janie Sheridan, Ms Annette Gohns, Ms Rachael Butler, Ms Amanda Wheeler

You are invited to take part in a collaborative study undertaken by the University of Auckland and Waitemata DHB to explore incentives and barriers in the transfer of clients on methadone maintenance treatment (MMT) from specialist to primary health care. We have contacted you because you work with clients of the Auckland Methadone Service (AMS). We are interested in your views of the reasons why some people decide to transfer to GP care, and some do not, and on the advantages and disadvantages of clients accessing MMT from GP care.

We would be grateful if you would complete the short questionnaire enclosed and return to researchers at the University of Auckland in the Freepost envelope provided. This should take less than 10 minutes to complete. Your involvement is entirely voluntary and completely anonymous. If you choose to participate, please can you complete and post this questionnaire within two weeks.

The results of this research will be written up as general themes and issues, with no individual responses able to be identified. No members of staff at the AMS will have access to your responses.

The information and learning gathered in the research will help us better understand the needs of clients on MMT and the issues they may face in transferring to GP care. If you are interested, a summary of the research findings will be made available through the AMS at the end of the study.

For research information contact Dr Felicity Goodyear-Smith at 373 7599 Ext 82357, Department of General Practice and Primary Health Care, School of Population Health, University of Auckland, f.goodyear-smith@auckland.ac.nz or you may wish to contact Michelle or Sheridan at the Community Alcohol and Drug Service (CADs) methadone consumer team, Tel 815 5830.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact the Health Advocates Trust Tel 0800 555 050 Northland to Franklin.

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PIS Version AMS staff #2 16/12/04 Reference AKY/04/12/337

Waitemata
District Health Board
Te Wai Awhina

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

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PARTICIPANT INFORMATION SHEET FOR GP PATIENTS

TITLE OF THE PROJECT: Transfer of opioid-dependent people on methadone maintenance treatment to GP care

RESEARCHERS: Dr Felicity Goodyear-Smith, Dr Janie Sheridan, Ms Annette Gohns, Ms Rachael Butler, Ms Amanda Wheeler

You are invited to take part in a collaborative study undertaken by the University of Auckland and Waitemata DHB to explore incentives and barriers in the transfer of patients on methadone maintenance treatment from specialist to primary health care. You are invited to participate because you are a client of Auckland Methadone Service (AMS) who has transferred to GP care.

If you decide to take part, you will be asked to complete a short questionnaire. This should take less than 10 minutes to complete. A Freepost envelope is provided to return the questionnaire to researchers at the University of Auckland. You can either give this to your GP or the practice nurse to send it for you, or post it yourself. If you choose to take this away with you please can you complete and post it within two weeks.

Your involvement is entirely voluntary and completely anonymous. The results of the research will be written up as general themes and issues, with no individual responses identified. No staff members at AMS or your general practice will see your responses. Your decision to participate or not will not influence your treatment in any way.

The knowledge gained from this research will help us understand the needs of patients on methadone maintenance treatment and the issues they may face in transferring to GP care. If you are interested in the research findings, a summary will be available through your community pharmacist at the end of the study.

For research information contact Dr Felicity Goodyear-Smith at 373 7599 Ext 82357, Department of General Practice and Primary Health Care, School of Population Health, University of Auckland, f.goodyear-smith@auckland.ac.nz or you may wish to contact Michelle or Sheridan at the Community Alcohol and Drug Service (CADs) methadone consumer team, Tel 815 5830.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact the Health Advocates Trust Tel 0800 555 050 Northland to Franklin.

This study has received ethical approval from the Auckland Ethics Committee
PIS Version GP PT #2 16/12/04 Reference AKY/04/12/337

Waitemata District Health Board Te Wai Awhina

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PARTICIPANT INFORMATION SHEET FOR GPs

TITLE OF THE PROJECT: Transfer of opioid-dependent people on methadone maintenance treatment to GP care

RESEARCHERS: Dr Felicity Goodyear-Smith, Dr Janie Sheridan, Ms Annette Gohns, Ms Rachael Butler, Ms Amanda Wheeler

You are invited to take part in a collaborative study undertaken by the University of Auckland and Waitemata DHB to explore incentives and barriers in the transfer of patients on methadone maintenance treatment (MMT) from specialist to primary health care. We have contacted you because you work with clients of the Auckland Methadone Service (AMS). We are interested in your views of the reasons why some people decide to transfer to GP care, and some do not, and on the advantages and disadvantages of clients accessing treatment from GP care.

We would be grateful if you would complete the short questionnaire enclosed and return to researchers at the University of Auckland in the Freepost envelope provided. This should take less than 10 minutes to complete. Your involvement is entirely voluntary and completely anonymous. If you choose to participate, please can you complete and post this questionnaire within two weeks.

The knowledge gained from this research will help us understand the needs of patients on methadone maintenance treatment and the issues they may face in transferring to GP care. If you are interested, a summary of the research findings will be made available through the AMS at the end of the study.

In appreciation of your willingness to contribute to this research, we would like to offer you a $30 book voucher as a small thank you. The number on your returned Freepost envelope will indicate that you have responded, but there will be no identifying features on the questionnaire you return, to maintain your anonymity. The researcher will receive the questionnaires, and an administrator will organise the distribution of book vouchers. GPs who participate in this study are also able to claim Royal New Zealand College of General Practitioner (RNZCGP) Maintenance of Professional Standards (MOPs) credits under Additional Professional Development Activities.

For research information contact Dr Felicity Goodyear-Smith at 373 7599 Ext 82357, Department of General Practice and Primary Health Care, School of Population Health, University of Auckland, f.goodyear-smith@auckland.ac.nz.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact the Health Advocates Trust Tel 0800 555 050 Northland to Franklin.

This study has received ethical approval from the Auckland Ethics Committee

PIS Version GP #2 16/12/04 Reference AKY/04/12/337

Appendix B: Questionnaires

1. Questionnaire for AMS clients
2. Questionnaire for AMS staff
3. Questionnaire for GP patients
4. Questionnaire for GPs

QUESTIONNAIRE FOR AUCKLAND METHADONE SERVICE CLIENTS

Thank you for agreeing to take part in this anonymous survey. Please do not put your name or any other identifying information on the questionnaire form. All forms will be returned to the University of Auckland, and you will not be identified in the research. Your answers will not affect your treatment in any way.

1. Gender: Male Female

2. Age: under 20 20-29 30-39 40-49 50+ years

3. Which ethnic group do you belong to? *(Tick the box or boxes which apply to you)*

NZ European Maori Cook Island Maori Samoan Tongan

Niuean Chinese Indian Other *(Please specify:* _______________)

4. How long have you been on methadone maintenance treatment?

Please specify: _______years _______months)

5. Do you currently have a GP? Yes No

6. Is your case manager encouraging you to transfer to a GP? Yes No

7. How do you feel about transferring to a GP? *(please tick one below)*

Very keen to do it Quite keen to do it Not bothered either way Not very keen to do it Not keen at all

8. Have you previously attended a GP for your methadone maintenance treatment?

Yes No

9. Below are some reasons why clients may choose *not to transfer* to a GP for their methadone maintenance treatment. Please indicate *how* much of a barrier each of these issues are for *you personally* by placing a tick in the appropriate box.

	Not a barrier at all	*A small barrier*	*Very large Barrier*
I have had poor service/treatment from GPs in the past			
I cannot get a GP in my local area			
I cannot afford to go to the GP			
I have unpaid fees at my GP			
I am worried that the GP might pass on information about my drug use to other people (e.g. family members, employees)			
I do not want my GP to be involved in my methadone maintenance treatment.			
It's a hassle to transfer			

PTO

10. What other reasons have stopped you transferring to a GP for your methadone maintenance treatment? *(Please detail below).*

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11. For each of the statements below, please indicate how much you agree/disagree by placing a tick in the appropriate box.

	Strongly agree	*Agree*	*Neither agree nor disagree*	*Disagree*	*Strongly disagree*
A GP would not provide as good a service as the methadone clinic I currently attend					
I would like to deal with one person for all my health needs					
I am worried that a GP might have a negative attitude towards drug users					
There is less stigma attending a GP than attending the methadone service					
I do not expect a GP to be as knowledgeable about drugs as my case manager					
I feel safer attending the methadone service					
I would miss my relationship with my case manager					

12. How likely do you think it is that you will transfer to a GP in the next 6 months? (Please tick ONE below)

Very likely Quite likely Neither likely nor unlikely

Quite unlikely Very unlikely

PTO

13. We have listed below a number of things that could help clients when transferring to a GP for their methadone treatment. Please indicate below how helpful these would be to you personally by ticking the appropriate box.

	Not at all helpful	***Quite helpful***	***Very helpful***
Information sheets or a handbook detailing what the transfer would involve			
A video showing what it is like to transfer			
A short education session			
Talking to others who have already transferred			
Having someone (from Auckland Methadone Service) accompany you on your first visit to the GP			
Knowing you could try it out and return to the specialist methadone service if you wished			

14. Is there anything else that you would like to comment on about transferring to a GP?

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Thank you for completing this survey
Please seal it in the reply paid envelope provided

For research information contact Dr Felicity Goodyear-Smith at 373 7599 Ext 82357, Department of General Practice and Primary Health Care, School of Population Health, University of Auckland, f.goodyear-smith@auckland.ac.nz or you may wish to contact Michelle or Sheridan at the Community Alcohol and Drug Service (CADs) methadone consumer team, Tel 815 5830. If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact the Health Advocates Trust
Tel 0800 555 050 Northland to Franklin.

QUESTIONNAIRE FOR SPECIALIST STAFF REGARDING CLIENT TRANSFER TO PRIMARY HEALTH CARE

Thank you for agreeing to take part in this anonymous survey. Please do not put your name or any other identifying information on the questionnaire form. All forms will be returned to the University of Auckland, and you will not be identified in the research.

1. What is your current position at AMS?

Case manager Other staff member

2. How many clients on methadone maintenance treatment (MMT) do you currently have in your care?

3. Approximately how many of your clients do you believe are currently stable (according to Auckland Methadone Service indicators of stability)?

4. For each of the statements below, please indicate the extent of your agreement/disagreement by placing a tick in the appropriate box

	Strongly Agree	***Agree a little***	***Neither agree nor disagree***	***Disagree a little***	***Strongly disagree***
I am actively encouraging my stable clients to transfer to a GP					
Many of my stable clients have shown little interest in transferring to a GP					
I worry that my clients who transfer to a GP will not receive as good a service as they do at AMS					
I am generally supportive of the transfer of clients from specialist to GP care					
Transferring clients to a GP creates an additional workload in my job (e.g. increased paperwork)					
I have concerns about GPs' attitudes towards clients on MMT					
I believe that some clients who have been identified as stable are not ready to transfer					
I believe that some clients are ready transfer but who do not meet AMS indicators of stability					
I believe that there are advantages for clients to receive their MMT from a GP					
Some clients get annoyed and/or feel pressured when I talk to them about transferring to a GP					

5. What do you think are the barriers for stable clients who do not transfer to a GP? (*Please list all barriers below.)*

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6. We have listed below a number of things that could help clients when transferring to a GP for their MMT. Please indicate how helpful you think these would be for clients, by ticking the appropriate box below.

	Not at all helpful	*Quite helpful*	*Very helpful*
Information sheets or a handbook detailing what the transfer would involve			
A video showing what it is like to transfer			
A short education session			
Talking to others who have already transferred			
Having someone (from Auckland Methadone Service) accompany them on their first visit to the GP			
Knowing they could try it out, and return to the specialist methadone service (AMS) if they wish			

7. If you have any other ideas/incentives that might encourage clients to transfer to a GP, please list below.

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Thank you for completing this survey
Please seal it in the reply paid envelope provided

QUESTIONNAIRE FOR AUCKLAND METHADONE SERVICE CLIENTS WHO ARE NOW ATTENDING GPS

Thank you for agreeing to take part in this anonymous survey. Please do not put your name or any other identifying information on the questionnaire form. All forms will be returned (anonymously) to the University of Auckland, and you will not be identified in the research. Your answers will not affect your treatment in any way.

1. Gender: Male Female

2. Age: under 20 20-29 30-39 40-49 50+ years

3. Which ethnic group do you belong to? ***(Tick the box or boxes which apply to you)***

NZ European Maori Cook Island Maori Samoan Tongan

Niuean Chinese Indian Other *(Please specify:* _______________)

4. How long have you been on methadone maintenance treatment?

Please specify: _______years_______months

5. When did you start going to a GP for your methadone maintenance treatment?

< 6 months ago Between 6 months and one year ago 1-3 years ago More than 3 years ago

5a. Is this GP based at a M ori Health Hauora provider?

Yes No

6. Below are some reasons clients may choose to transfer to a GP for their methadone maintenance treatment. Please indicate how much of a reason each of these issues were for *you personally* when you transferred by placing a tick in the appropriate box.

	Not a reason at all	*Part of the reason*	*The main reason*
I wanted to free up a space for someone on the methadone maintenance treatment waiting list			
I wanted to deal with one person for all my health needs			
I wanted to be able to access after-hours appointments			
I wasn't happy with the service I was receiving at the methadone service			
I wanted to move away from a specialist drugs service, into a more mainstream health service			
I thought I would get more takeaways			

The GP is closer to where I live			

PTO

7. Are there any other reasons why you transferred to GP care? *(Please detail below)*

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8. For each of the statements below, please indicate the extent of your agreement/disagreement by placing a tick in the appropriate box.

	Strongly Agree	*Agree*	*Neither Agree Nor Disagree*	*Disagree*	*Strongly Disagree*
There is less stigma attending a GP than being a client of the methadone service					
I felt pressured to transfer to a GP					
I have more rights as a GP client as I am paying for the service					
Before transferring, I was worried that a GP might not provide as good a service as the methadone service					
Before transferring, I was worried that a GP might have a negative attitude towards drug users					
I am able to get appointments at the GP at times that suit me					

9a. Would you say that seeing a GP for your methadone treatment is:

Better than attending a specialist methadone service	*Worse than attending a specialist methadone service*	*Neither better nor worse than a specialist methadone service*

9b. Please detail your reasons for this below

____

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____

PTO

10a. How likely do you think it is that you will transfer *back* to the methadone service in the next 6 months? (Please tick one box below)

Very Likely *Quite Likely* *Neither likely nor unlikely* *Quite unlikely* *Very Unlikely*

10b. If '*quite likely*' or '*very likely*' that you will transfer *back* to the methadone service, please state below the reasons why you are likely to return.

____

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____

11. We have listed below a number of things that could help clients when transferring to a GP for their methadone maintenance treatment. Please indicate below how helpful these would have been to you when you transferred, by ticking the appropriate box.

	Not at all helpful	*Quite helpful*	*Very helpful*
Information sheets or a handbook detailing what the transfer would involve			
A video showing what it is like to transfer			
A short education session			
Talking to others who have already transferred			
Having someone (from Auckland Methadone Service) accompany you on your first visit to the GP			
Knowing you could have tried it out and returned to the specialist methadone service if you wished			

12. Is there anything else that you would like to comment on about receiving your methadone maintenance treatment from a GP?

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Thank you for completing this survey
Please seal it in the reply paid envelope provided

For research information contact Dr Felicity Goodyear-Smith at 373 7599 Ext 82357, Department of General Practice and Primary Health Care, School of Population Health, University of Auckland, f.goodyear-smith@auckland.ac.nz or you may wish to contact Michelle or Sheridan at the Community Alcohol and Drug Service (CADs) methadone consumer team, Tel 815 5830. If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact the Health Advocates Trust Tel 0800 555 050 Northland to Franklin.

QUESTIONNAIRE FOR GPS CARING FOR PATIENTS ON METHADONE MAINTENANCE TREATMENT (MMT)

Thank you for agreeing to take part in this anonymous survey. Please do not put your name or any other identifying information on the questionnaire form. All forms will be returned to the University of Auckland, and you will not be identified in the research.

1, Location of practice within Auckland: Central West Eastern Suburbs

South North Shore

2. Size of practice _________ *(please write in number of patients under your care)*

3. How many patients on MMT do you currently have in your care? ______________

4. Approximately how long have you been prescribing methadone under authorisation from the Auckland Methadone Service (AMS)?

Please specify: _______years _______months

5. For each of the statements below, please indicate the extent of your agreement/disagreement by placing a tick in the appropriate box

	Strongly agree	*Agree a little*	*Neither agree nor disagree*	*Disagree a little*	*Strongly disagree*
Patients on MMT are no more problematic than other patients					
I feel supported by AMS in dealing with patients on MMT					
My appointments with patients on MMT are sometimes rushed					
I feel confident that patients on MMT receive a good service fron practice					
I support the transfer of patients on MMT from secondary (specialist) to primary health care					

6. How willing are you to receive further patients on MMT in the next 6 months? *(Please tick one below)*

Very willing Willing Neither willing nor unwilling Unwilling Very unwilling

7. Below are some reasons we believe GPs choose *not* to take on further patients on MMT. Please indicate how much of a barrier each of these issues are for *you personally* by placing a tick in the appropriate box.

	Not a barrier at all	*A small barrier*	*Very large barrier*
Patients on MMT are often disorganised (e.g. need takeaways at short notice)			
Patients on MMT often have co-existing disorders			
There can be problems with prescriptions for patients on MMT			
Patients on MMT need longer appointment times than my other patients			
Patients on MMT often have unpaid bills			

Patients on MMT who transfer are not always stable (or what I would define as stable)			

PTO

8. **Below are some reasons we believe patients on MMT may *not* wish to transfer to GP services. Please indicate how much of a barrier you think these are *for patients,* by placing a tick in the appropriate box.**

	Not a Barrier at all	*A small barrier*	*Very large Barrier*
They have had poor service/treatment from GPs in the past			
They cannot get a GP in their local area			
They can't afford to go to the GP			
They have unpaid fees at their GP			
They are worried that their GP might pass on information about their drug use to other people (e.g. family members, employees)			
They don't want their GP to be involved in their methadone treatment			
They don't want to leave the specialist service			

9. We have listed below a number of things that could help patients when transferring to a GP for their methadone treatment. Please indicate how helpful you think these would be for patients, by ticking the appropriate box below.

	Not at all helpful	*Quite helpful*	*Very helpful*
Information sheets or a handbook detailing what the transfer would involve			
A video showing what it is like to transfer			
A short education session			
Talking to others who have already transferred			
Having someone (from Auckland Methadone Service) accompany them on their first visit to the GP			
Knowing they could try it out, and return to the specialist service if they wished			

9. **What else do you think could be done to encourage more patients on MMT to transfer from secondary (specialist) to primary health care? (*Please detail below)***

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Thank you for completing this survey
Please seal it in the reply paid envelope provided

Appendix C: Log forms for AMS staff & GPs recruiting clients / patients into study

1. Questionnaire distribution form for AMS case managers
2. Questionnaire distribution form for GPs

Transfer of Methadone Clients to Primary Care Research
Questionnaire Distribution Form

Case Manager Name: ____________________________

Please write in the total number of your clients who have been identified as ready to transfer: _____

- Please tick the appropriate box after each client's appointment
- Once you have completed this, **please cut off the client names** and return the form to Karen Vince

%

Client Name	No.	Questionnaire Given	Client Declined	Client Did Not Attend
	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
	10			
	11			
	12			
	13			
	14			
	15			
	16			

Transfer of Methadone Clients to Primary Care Research
Questionnaire Distribution Form

Please write in your total number of methadone patients: ___

- Please tick the appropriate box after each patient's appointment
- Once you have completed this, **please cut off the patient names** and return the form in the freepost envelope provided, or fax to 09 3737624 (at the University of Auckland)

%

Patient Name	No.	Questionnaire Given	Client Declined	Client Did Not Attend
	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
	10			
	11			
	12			
	13			
	14			
	15			
	16			
	17			
	18			

Appendix D: Free-text responses coded into themes

1. Thematic analysis: AMS clients
2. Thematic analysis: AMS specialist staff
3. Thematic analysis: GP patients
4. Thematic analysis: GPs

1 Thematic analysis: AMS clients

QU.10: WHAT OTHER REASONS HAVE STOPPED YOU TRANSFERRING TO A GP FOR YOUR METHADONE MAINTENACE TREATMENT?

Nature of General Practice / Patient relationship
Confidentiality
I don't want to go to the other one in my area as my [family member] knows the receptionist there
Stigmatisation
I was made to feel like a scumbag and a second class citizen for trying to do something about my addiction.
I have many other health issues at my GP and I worry the understanding of drug addiction with GPs and other medical doctors come with a lot more preconceived notions and stereotypes. Some think because you're on a stable dose you are stoned all the time and won't treat pain as seriously.
Perceive GP service to be lower standard
They are very ignorant regards dope fiends
The GP and the staff are not qualified to be aware of our individual circumstances.
I've heard bad things about 1 of the 2 GPs in my area who do do it.
I feel GPs would not have as in depth a knowledge of drug issues and how to deal with clients.
Transferring to a GP is a trust issue – ie. Can you trust your GP to understand some of the related problems which go along with some methadone consumers
From talking to methadone clients, they seem to con GPs to a certain degree.
Probably too restrictive.
Previous negative experience with general practice
I have already been to a GP for my treatment. It was a disaster. I felt I had no support. I had nothing but drama and I could not wait to be with the programme again.
Experience I have had with GPs in the past. Very judgemental. Don't seem to understand the methadone system at all. Cannot understand addictions etc.
I felt both were very judgemental and confrontational, and had either little or no information about methadone. Being a fragile person, mentally anyway, I became very distressed about both incidents [with GP], which could have easily set me back in my rehabilitation if I didn't have my caseworker to talk to.
I felt very isolated.
I have in the past, had several incidents with a GP and a specialist.
Fear of Unknown
I'm not sure about the other doctors as I don't know them
Re-establishing a relationship
Increased responsibility
Plus a GPs visit is monthly, I have a bad memory. Whereas CADS is monthly and they let me know when and where to turn up. I'm on this maybe for life. GP is 12 times a year, where CADS is only 4 times a year, not hard to work out. Maybe for the long stayers you should let GP visits be 3 monthly instead of monthly, big hassle and a lot of wasted money.
Have good relationship with GP
I have spoken with my GP of this important matter. I have since found out that my GP is now open to receive and understand the benefits of dispensing (with a caring response)

this type of medication. 'Bravo to the GP' for his enquiring nature.
GPs cover many health issues in a broader spectrum of conditions.
Want separate GP for MMT
I like and respect my lady doctor, and feel she might not understand about drugs as she is [not an NZer], but very good with other woman complaints. I therefore prefer to keep the two issues separate.
More / less takeaways with GP service
I was told that a GP could prescribe more 'takeaways' – ie less visits to the chemist. If this is true, it would be extremely helpful!
Some people will see it as a licence to abuse and sell extra takeaways provided by GPs.
Access to GP
I belong to 'x' practice and have been told they don't do methadone
And he has told me he is not interested in the methadone programme. He is a good family Dr who is flat out. He doesn't need it, which I can understand
My own GP won't do it
My GP has never dealt with methadone maintenance treatment. He may only take a client on if they are detoxing.
Finding a good GP
Good relationship with specialist service
Also I enjoy the contact of having a case manager. I don't have many friends and if I have any hassles they're good to talk to
I enjoy going to see the people at CADS. I relate more to them than my doctors and the people there.
Because at the moment I am trying to come off methadone and feel I would get more support and understanding from staff and my case worker at RADS [CADS]
It took a very long time to even consider going on the methadone programme. I feel very comfortable with the doctors, not to mention my case manager. I prefer attending the methadone service
I am happy with the service and care of CADS. I find having a caseworker that focuses on just methadone and its issues is better for me.
CADS is better for me – they know my history and situation with no judgement.
None. I prefer to see a case manager. It's a stability thing with me.
I like the personal touch my case manager gives me.
The methadone is good, no crime, no getting sick, lot calmer. Keep up great work.
I am grateful and thankful to have had a compassionate case manager in.
I wish to stay where I am. I have had many an opportunity to reuse. But because of the environment at the CADS centre with their doctors and case managers, that they have made me feel determined to keep off using. It's not to say that in time I may change, but this is where I wish to stay.
Financial – cost is a barrier
My GP is a great family doctor for me and my kids. He doesn't charge me which is great as I'm on a very tight budget. I feel the money spent at the doctor is robbing my kids of many things that they need week to week
The only reasons I can think of to the negative would be cost per visit to GP.
It was not working for me financially
I've heard of GPs refusing to write scripts if client has no money, and this could be a problem for me.
I can't afford to pay for visits to doctors to see if I like them.
Doctor's fees
Education

Education of clients
'We' as individuals need to be educated on our enquiring skills for the right reasons.
There is not much information on it – e.g. The cost. I know you would have the doctors bill, but would you have to pay for the 'dose'? A booklet would be very helpful
Education of GPs and support staff
My GP has not had the necessary training
My GP has never dealt with methadone maintenance treatment. He may only take a client on if they are detoxing.
If a training period is needed for the GP, it would have to be arranged so not to interfere with an already busy schedule.
CADS is specifically for drug withdrawal and drug dependence issues. CADS are more like going to a specialist for a condition
Shared care approach / transition period
I really think it is important to have the extra support of case managers. I think that people should still see their case managers for a period of time, like a probation period.
I really like the suggestion about how you could return to the specialist methadone service if you like.
As long as decisions made by the GP are not overridden by methadone service employees, otherwise what is the point (within reason naturally).

2 Thematic analysis: Specialist staff

QU.5 : WHAT DO YOU THINK ARE THE BARRIERS FOR STABLE CLIENTS WHO DO NOT TRANSFER TO A GP

Financial – cost is a barrier
Financial (many clients on WINZ benefits)
Finances
Increased cost
Cost (PHOs should subsidise GP methadone visits)
Cost
Cost of consultation
Previous bad debts – doctor shopping etc.
Finance
Cost
Cost
Issue about cost
Financial concerns
Cost
Money
Financial outlay
Cost
Lack of money
Cost of GP fees
Good relationship with specialist service
Good relationship / trust with case manager
Have a good relationship with CM
If it ain't broke don't fix it
Feel insecure about breaking a successful relationship with AMS team
Accustomed to AMS and resist change
Loss of contact with us. Value their contact with us
Prefer specialised input
Relationship they have developed with case manager
Nature of General Practice/Patient Relationship
Confidentiality
Not wanting to disclose to a GP
Not wanting GP to know drug problem exists
Confidentiality/insurance concerns
Family GP
Stigmatisation
Stigma (often family GP unaware patient on MMT)
Stigma
Being further stigmatised
Perceive GP to be of a Lower standard
Client anxiety about transfer
Staff anxiety re: transfer
Client worried that GP does not have sufficient knowledge/experience in MMT
Fear GP 'not organised' to do scripting on time

No personal one-to-one
No real advantage in them transferring (except the perception of more takeaways and less interventions. This would appeal to unstable clients).
Shortness of appointments with GPs
GPs have limited time
Lack of specialist care
Lack of understanding GP
Concerns for reduced support/availability
Issues around losing a support system
Previous Negative Experience with general practice
Bad experiences with GPs in past
Previous bad experience with GP
Fear of the Unknown / Anxiety about change
Feel insecure about breaking a successful relationship with AMS team
Accustomed to AMS and resist change
Fear of the unknown
The unknown (scared of making a change)
Issues around accepting change
Increased anxiety
Fear of abandonment
Increased Responsibility
Quality of service provided by AMS (e.g. clients have scripts managed by AMS. With GPs, they have to manage this)
Unable to take responsibility for scripts, consultations etc.
Having to be responsible for appointments / scripts etc.
Continuity of Care
Loss of continuity
GP service more lenient / offer greater flexibility (+ and -)
Less monitoring
Stable clients like the monitoring with AMS
Difficulties accessing an authorised GP
Don't know GP
Client's GP not willing to prescribe methadone
Inability to access GP regularly
GPs not in their area who are prepared to dispense methadone
Why should stable clients have to transfer to GP care if they have no current contact with a GP for other health concerns?
Finding a suitable GP, who is willing and able to prescribe
Finding a GP they trust
Finding a methadone prescribing GP
More/less Takeaways with GP service
Less flexibility with arranging takeaways.

QU.7: OTHER IDEAS/INCENTIVES THAT MIGHT ENCOURAGE CLIENTS TO TRANSFER TO A GP.

Financial – modification of current funding system
Free prescription charges up to 3 items on other prescribed medications
Monetary assistance
An allowance over and above community services card
Free repeat scripts
Cost (PHOs should subsidise GP methadone visits)
And GP charges to scripting
Perceive GP service to be lower standard
I would question the seeming automatic assumption that the best place for stable clients is MMT with a GP. There is a strong argument that a client is supported in their stability by worthwhile and wholesome CM and MO intervention.
Shared care approach / transition period
Shared care – i.e. transition period where CM and GP co-manage client (e.g. for 6 months)
Shared care approach for a transition period between management by AMS and sole management by the GP
Transfer to GP built into client programme
Should be made an inbuilt part of the pathway to move clients to the GP programme. Should be part of the system when they first come in for stabilising
AMS support for initial GP visits
Good support for new GP prescribers
CM also to liaise/attend GP appointment
Formal introduction to practice nurse
Education of Clients
If the clients could somehow be sure that the GP was friendly and wanted to be involved in their care. Perhaps a pamphlet with a statement from various GPs outlining client centred approach
Demystifying the process
More/less takeaways with GP service
Increased takeaway doses
Other (miscellaneous) comments
Matching of client needs to practical incentives

3 Thematic analysis: GP patients

QU.7: ARE THERE ANY OTHER REASONS WHY YOU TRANSFERRED TO GP CARE? QU.9B: DETAIL REASONS FOR SAYING GP IS BETTER/WORSE/NEITHER BETTER NOR WORSE THAN ATTENDING A SPECIALIST METHADONE SERVICE

Nature of General Practice / patient relationship
Confidentiality
It's possible to meld with everybody at the surgery because you're not by your presence a 'low life abuser', which is just one of several worthy reasons
So nobody is any the wiser about my condition
Lack of privacy. Attending my GP doesn't make me a potential target of police interest, and no-one there knows
It is an anonymous service where the addiction issue is treated as a medical issue
I feel the GP is more anonymous
Greater levels of privacy
Remember I'm talking [many] years ago. The service had no individual programmes. If one person on the programme did something adverse everyone suffered (big time). My GP is marvellous. I can tell him anything and know it won't be discussed by a 'team'!
Stigmatisation + or - / normalisation
It doesn't have the stigma like going to base for daily doses. People know what you are there for. At GP no-one knows why you are there except you and GP.
In general and maybe because of my age I feel much more freedom, and really more like a person with any other medical problem like diabetes for instance, who needs medication each day. Not so much stigma attached, and I just get on with life.
There is still a lot of stigma from the public towards methadone especially in my small town. Keeping things more confidential would help. For example, not having to drink my dose in public at the chemist would help. Also more 'need to know only' at doctors as the local nurses and doctor's receptions tend to gossip.
The added discretion of attending a GP helps to reduce the damaging and unpleasant negative stigma associated with attending a 'drug addict's clinic'.
It's great to have a GP that treats me knowing I'm on methadone
I do not understand why the big deal is made about going. Getting prescription medication should be a right to all not some.
And I didn't feel as if I was being judged in that negative light
I feel like addiction is a 'normal' health condition that I can take responsibility for.
It is an anonymous service where the addiction issue is treated as a medical issue
Treated with more respect [at GP]
Also freedom from institutions
As the next logical step in the rehabilitation progression
Main reason was to get away from the clinic. That is, I wanted the mainstream health service
The Auckland methadone clinic was one of the most caring and sincere clinic I've been to.
The years spent attending the clinic were very helpful and there was always excellent support for me.
In my case I found the experience of being assessed as stable, reliable enough to move on to GP administered care was much needed positive reinforcement of progression toward overall rehabilitation. Somewhat of a graduation to the next level of your recovery.
It just helps you feel more like someone who is reintegrating into society. You are a person

with rights and a valuable member of the community, not a person with a chemical dependency problem and a burden to society which is something you feel sometimes.
Once the specialist team have evaluated a patient to be stable, and/or improving and no longer in need of their more focussed attentions, it is better for both the specialists and the patient for the patients to be administered by a GP.
or the patient comes the feeling of progression towards rehabilitation
Very satisfactory – normalises receiving maintenance medication.
Also I've always considered methadone to be like a medication, not a substitute drug.
Building and developing an ongoing healthcare relationship with a highly qualified doctor who was trained and sympathetic to the needs of people on methadone. And who sees it as an 'illness' NOT a mental disorder/personality trait or dysfunction
Greater control over treatment
Main reason for me is the fact that I can pick up twice a week and do not have to take time off work.
To finally have control of my own life, in that **I** plan to see doctor for **MY** next script, and I'm not reliant on a caseworker to remember and get it to the pharmacy on time (which they have failed to do on a number of times)
And ability for doctors to facilitate withdrawal and move on in life
Just for more independence and control over my own life decisions
I wanted more control over my treatment
One feels more responsible for one's own treatment
More control in my hands. i.e. scripts are up to me to arrange not left to CADS (who have got it wrong on more than one occasion)
Ability to truly discuss one's own situation, with own doctor and have more control over my MY LIFE. Not just a number as it is with CADS
No enforced 'counselling'
No feelings of compulsion
I feel more in control rather than controlled
I don't get so stressed as can make my own appointments. Just feel I am more in control
Gives me more independence
It helps you take control of your life more.
(-) Clinic faxes scripts and so that was one thing I didn't have to worry about.
One person for all my healthcare needs
Yes, I do like my GP in all ways for all my care
Because the GP I see for my methadone treatment I also see for everything else
I have other health problems, so I thought I could do all of them at once.
I thought it sensible to have one person to deal with all my health needs
Doctor appointments can be all inclusive and doctor give very good updates from healthcare services
To integrate the treatment of my drug related health issue with my overall health care.
Wanted someone who understood my whole situation
My GP knows me in all other aspects of my personal healthcare and I felt this was a better way to deal with things. As she has a whole picture of me as a person, and I felt more comfortable with this.
Happens to be my family GP as well. Two birds with one stone sort of thing. Works well for me.
Also can keep your other sickness under control
My doctor has all my files on my health problems over the years since I was born, records of all my operations etc. so I feel more comfortable with him.
One doctor looking after my entire health, not just methadone health

You can discuss other health problems associated with methadone use
Seeing one health specialist
And the doctor knows about all my health problems, which I think is better for everyone on methadone
Being at my GP and having to visit him each month for my script gives me opportunity to get other health issues dealt with. I wouldn't go to GP very often usually.
And the obvious benefit of having one doctor who is fully conversant with the patient's health – both programme-related and non.
They can assist me in maximising my overall health. Although some GPs don't have as clear an understanding of drug use as CADs my health needs are holistic and not just about access to drugs
All round health issues can be discussed and methadone affects general health issues
Get to know doctor. Can discuss other health issues – smoking, fitness, hepatitis, depression.
Dealing with my other medical problems all at once is great.
It works out for me to be going to GP care because I'm always having health problems so I visit my GP more.
I asked for GP so I had just one doc for all my problems
All needs catered for
Your GP knows you a whole lot better than a random GP and would be better able to service your medical and to some extent, emotional needs.
I think methadone treatment should always have GP input. They heal, so they must know everything concerning individual and health.
Doctor gets my full medical conditions such as treatment for depression, Hep C.
It's a one-stop health service
It is more convenient for me to see my GP as I can discuss other health issues
Also that methadone treatment is more than just taking methadone to help our bodies reject drugs. With a GP as our guide through this journey of recovery then our bodies need other things of help as well. It's a perfect setting.
Feel that it is logical to see my GP as I can monitor my overall health.
Also I needed a GP and felt one that could treat me for everything would be to my advantage.
Understand my medical and mental health matters
You do have to renew your script once a month but your GP is your counsellor all in one.
I like having the doctor address all of my medical
As is having a doctor knowing my analgesics needs (actual rather than hopeful or withholding). A one stop health shop, yeah?
Also he knows other things about my background that may assist with my treatment
Seeing one doctor for all my treatment is good, so I don't have to go here and there for one little thing.
For me personally it has put me more in touch with my health and wellbeing.
In the past I had only seen the clinic Doc for methadone and put any other problems (like smears etc.!) on the back burner.
Only see one doctor, not many different ones. Only have to tell one person your 'life story' not many (as caseworkers seem to change almost MONTHLY).
I was worried that if I dealt with CADS at the time, I may get different caseworkers and such. With a GP you need not worry about it if your GP is also the family doctor.
No staff changes
The person I deal with is always the same person, he is consistently the same person so he knows my entire medical history

I only have to deal with one person rather than seeing a new one every appt.
Long-term one-to-one with same provider.
Have good relationship with GP
My GP is a very very very nice person, she is not nasty and jumps at you. She is prepared to listen and talk with you.
GP outstanding, reluctance would be worrying if I had to switch GP, haven't done this.
GP is sympathetic, keen to help. Treats me with respect. Attitude not based on (negative) experiences with other people and cynical belief that they 'know my type' (there is not such thing!)
My GP knows me now and we have a good relationship.
Trust
My GP who has been my GP for many years is very understanding and I have complete trust in him. I feel I can confide in him if any problems may arise.
Because my GP has known me for many years and knows my history
She cares about my needs. Everything she does is always in my best interest. I trust her.
It's more one-on-one service cos it's way more personal
I feel comfortable with my GP and am able to be honest with him regarding health issues
I have an established relationship with my GPs
One on one with a male doctor is good for me. The more I get to know my GP the more I like him as a person, and professional. Vice versa I assume, great doctor.
Feeling of genuine interest in my health care enabling me to be open and honest
and he is helpful, non judgemental
Feel more relaxed
Treatment is on a more personal level
My GP knows the methadone treatment plans and policies plus my personal circumstances. He treats my personal needs and I'm not treated like a sheep.
Easier to deal with an individual rather than an organisation
Knew my doctor before transferring, was able to talk to my doctor about it. Plus my reason was to get somebody deserving onto the programme as I know what it's like to scavenge out on the streets.
I am extremely lucky to have a wonderful doctor who understands me and is thrilled with my stability and willingness to come off methadone ASAP.
I have been more than pleased with all the help I have received from the service, thank you very much for another life saved from drugs that kill.
I feel very strongly the success or failure of anybody transferring to GP service has everything to do with the attitude and vibes one get from the doctor and staff involved
In my experience the GPs that join the programme are generally empathetic and treat their clients very well. They tend to have done research into addiction and have an interest. Many non-programme GPs seem fearful of it.
Great improvement communication skills
I wouldn't change back to the methadone service as I couldn't be more happy going to my GP
I enjoy the one-on-one, and relationship formed. I was with my previous GP for many years, just very helpful, with empathy.
Very good treatment
Today I am clean, hold down a fulltime job (two years) and am starting up my own business, thanks to the GP scheme.
My GP and I are going just fine. My GP is great, she listens to what I've got to say. She is also my family GP.
I am quite satisfied.

My GP just sold his practice, but I was lucky to find the new GP supportive.
Improved with time.
Doctor very good. I'm quite happy there.
It works fine. If it works, don't fix it.
I am happy and satisfied with my situation. It works for me.
The private GP system works extremely well for me and I am very grateful to be given that option.
I respect my GP and methods, whereas I've never respected a methadone service counsellor nor the clinicians and doctors.
No pressures come from the doctor, but the ability to talk of dosage change (up or down) or even illicit drug use without fear of unannounced responses is a major relief
(-) The doctor is not an easy touch and I think this is good for me
I personally have found it extremely good, and hope anyone else who does get to change
Overall GP service is just BETTER. I feel like a person whose life and opinion mean something, not just treated like a druggie who's only looking to score.
Better, more egalitarian service.
Less procedural rigmarole
Way better. Less B.S. all the way round.
It just helps you feel more like someone who is reintegrating into society. You are a person with rights and a valuable member of the community, not a person with a chemical dependency problem and a burden to society which is something you feel sometimes.
The doctor I'm under is very understanding towards me
My GP was very supportive of helping me reduce my chemical dependence and I had always been totally honest with her
And I also feel more comfortable with my GP
I have a good, honest, open relationship with my GP and I find that's important in my recovery and maintenance programme
GP very understanding
I wanted personalised care
To be known as a person, not just another number
GP care is so much more personal, building the trust that is required.
Building and developing an ongoing healthcare relationship with a highly qualified doctor who was trained and sympathetic to the needs of people on methadone. And who sees it as an 'illness' NOT a mental disorder/personality trait or dysfunction
Personal service
Know I could trust her attitude, unlike some AMS staff – this can be variable
Don't feel I have to give long explanations (or beg) to unsympathetic, anonymous person at the other end of the phone.
Better service
(+) Overall GP service is just BETTER. I feel like a person, whose life and opinion mean something, not just treated like a druggie who's only looking to score.
Views drug dependence as a medical condition / illness
GP more convenient / flexible
I work a 40 hour week and obtaining time off to attend appointments was becoming a 'pattern'
Flexibility of travel etc.
Including better access
Convenience was the main motivation
More convenient for me when it came to working
Access

The case worker office was a half hour drive when the GP is five minutes away.
GP takes a commonsense approach and is prepared to be flexible
Greater flexibility
(-) My GP informed me that he does not like to interfere in the prescribed dose, which meant returning to the methadone service for any changes in dose
Now that I'm working, the pressure of having to go into Methadone services each day at a certain time is off. I can make my appointments when I can manage and not have to fit in when the methadone services can see me.
Planning appointments
It also made my life easier because scheduling hour long visits to CADS and so many commitments was affecting my career.
I'm close to doctor's surgery
Being closer to my home
Closer to home
Easier to make appointments
Being closer to home will save gas money and will be easier [because I am disabled]
Closer to home
No transport problems
As working, I have more time to see my GP
It is much better for me because I work and I can get to see my GP after my work hours because he does not close until 6 o'clock. With the methadone service I was always having to take time off work, which almost cost me my job. GP is much better for the working man, women.
Local instead of [going to AMS]
Doctors always available
I find it more convenient
Travel distances
Closer to home [disabled]
It was really a mission to get transport for the maintenance programme visits.
The biggest hassle now is getting to my doctor (this is fate, nobody's fault).
If you don't have a car, it's a lot more convenient.
Sometimes having an accident or not being able to make my pickups is hard to cope with, getting sick. But a GP helps me get my doses through my spouse, who is also on the programme. It doesn't happen that often.
It has been good with no worries. It was always a hassle to get into [AMS]
It has been much easier to see my GP
Financial
Cost is a barrier
If I had realised the extra costs involved and hassle with transportation I probably wouldn't have (my GP is great and I am not placing any fault with her, but she has moved a couple of times. When I first went to her she was in x, but has since moved to y and then z over the years. And as I wanted to stay with her I have, but I have no car and I work so it can be difficult getting to her).
The cost of [transport] was rather high
NB. The COST of doctor's visits at $25 approx (on high user card) is too much for many people – subsidise visits. Even a repeat is $15. Take away cost (reduce if possible)
I've found the expense is huge being on a GP scheme but it was something I was willing to make allowances and sacrifices so I could afford to attend a GP. My Dr charges $40 for my script which on a benefit is a lot. But I don't have a lot of choices [in the area] I live and I've been told I possibly can't go back to CADS now, so I tend to go without. I don't have

any health probs apart from Hep C so $40 for scripts is over-the-top
Also, a bit thing for me was the cost of a doctor's visit each time I needed a new prescription each month.
The one negative being it was free to attend CADS, however it does cost more at the GP. $35 every three months, plus $10 prescription costs every other month.
Most people should be given the opportunity ASAP except where significant risk exists, or cost can be a barrier.
NB. The COST of doctor's visits at $25 approx (on high user card) is too much for many people – subsidise visits. Even a repeat is $15. Take away cost (reduce if possible)
Fantastic service although more costly
The cost of transferring to a GP. I didn't understand that when I originally changed over.
Just that the charge of getting my scripts. Other than getting my scripts I don't go to the Dr's, so the charges are over the top and it doesn't surprise me that more people don't transfer. Because of cost.
Financial – cost is an incentive or NOT a barrier
Cost of travel more than GP cost
It worked out that it's cheaper for me
I found a doctor at the right price for me to afford.
Clinic was also far away but didn't make me pay for appointments. Balances out I guess.
I could also afford GP treatment so I was one of the 'lucky ones'
Being closer to home will save gas money and will be easier on my injury
Dissatisfaction with specialist service
A the time the methadone service was run by people who weren't interested in why drugs were used, but as a punishment programme.
I was on benzodiazepines and friends had advised me not to tell the clinic, so I felt like I was living a lie.
Too long ago to recall properly, but I do recall difficulties with various case workers, that seemed unable to understand me and my needs.
I seemed to be treated as a 'criminal' when I was attempting to improve my life. I needed rewards, not restrictions as I did the programme properly.
Sometimes I couldn't make it to CADS because of my injury and that ended my contract and I had to go back on a waiting list twice
Know I could trust her attitude, unlike some AMS staff – this can be variable
Don't feel I have to give long explanations (or beg) to unsympathetic, anonymous person at the other end of the phone.
Unprofessional, unreliable and non-standard levels of care varying from city to city, and between counsellors who have too much personalised input
I had lost faith with the people I was dealing with
I felt more comfortable talking to my own GP about concerns and issues as counsellors and doctors are continually changing at CADs or AMS
Every time I went to clinic, staff would go on and on about GP scheme. I was happy with my case worker and said no. Then my case worker left and new case worker not really onto it, so I went for GP scheme
Better to have to tolerate the arbitrary decision making of one person, rather than those of a collection of 'odds and sods', i.e. CADS
Increased ability to actually contact my Dr when needed, unlike CADS where you leave messages and hope someone contacts you back
Perhaps if more 'aware' case workers I would say different. But no 'street' cred with two I had (my opinion)
A very few minor things happen differently within a GP service. For starters there is no

oppressive, negative attitudes from overworked, underappreciated methadone staff
I respect my GP and methods, whereas I've never respected a methadone service counsellor nor the clinicians and doctors.
Ability to truly discuss one's own situation, with own doctor and have more control over my MY LIFE. Not just a number as it is with CADS
Only see one doctor, not many different ones. Only have to tell one person your 'life story' not many (as caseworkers seem to change almost MONTHLY).
I would never wish to return to a 'clinic' situation, which I found very disempowering.
Encouraged by Caseworker
My case worker suggested I transfer to a GP after I had been on the programme for about three years. I didn't know about the GP service till then.
The waiting list was too long, so the methadone service – CADS said to go private
Free up space on MMT waiting list
Mainly to free up a space for someone else on the programme
I think people should not be so selfish about not going on GP thing, cos it frees up people waiting to go on, which can take more than six months. That's a long time when you have a problem.
Knew my doctor before transferring, was able to talk to my doctor about it. Plus my reason was to get somebody deserving onto the programme as I know what it's like to scavenge out on the streets.
I got to a point where I was very stable and figured there was a lot of other people waiting to come on the programme
Frees the specialist team to concentrate on their cases requiring greater attention.
To avoid other drug users / previous drug using scene
To get away from seeing people that I didn't want to see, still using.
I wanted to not see all the old junkies from my past. I needed to change the people I worked with, to achieve the absolutely formidable tasks I had set for myself.
I wanted to break away from association or bumping into drug addicts, associates etc. I need anonymity. GP scheme for me has been a step forward.
Did not want to have to associate/see with others on the programme
Non association with users (fellow users) whilst at appointments
I wanted to get away from the drug scene, and have been working ever since
Trying very hard to stay away from other patients, and always bumped into them at CADS
I did not want to be picking up with other addicts, people I used to know. Try to change people I associated with.
Did not want my family exposed to other clients at methadone service
Preferred not to associate with drug dependent people
It is not a meeting place for users
not having to go to one place to pick up with everyone else on the programme. There is much less chance of me re-meeting old acquaintances going to my own GP
I didn't like running into people at clinic
Don't have to see any other AMS clients
Do not want to run into other methadone clients
Don't have to see people I might not want to associate with
Don't have to see other people with drug problems. Much better for me as a person
I had to keep away from other users, at that time I was the only methadone client in my area it worked good.
Am away from the drug users who abuse the system
There is less contact with ex and active illegal drug users
The main reason I went to the GP scheme was to get away from seeing all my using

mates on a daily basis, every time I would see them I would relapse! Staying out of the playgrounds have definitely helped.
Gets you away from the bad drug lifestyle associated with the methadone service.
You don't have to see or hang out with other drug users that are living, clean or not. Or seeing people you know there, drug circle.
More / less takeaways with GP service
The main reason is because I work. I can get a better takeaway system with my own GP.
More 'takeaways'. I.e. During the working week, makes for less down time waiting in pharmacy every day.
Main reason for me is the fact that I can pick up twice a week and do not have to take time off work.
And over time I wanted to receive full takeaways
Hopefully getting full takeaways will save money and time because I have to pay the GP off weekly which I hate.
Because I built trust with my GP I also had increased takeaways which made my career goals easier to achieve and maintain
Hopefully getting full takeaways will save money and time because I have to pay the GP off weekly which I hate.
Plus being on takeaways I sometimes get called away at odd time to do repair work for my job.
Depending on one's track record a little more leniency regarding takeaways is well overdue. I'm referring to people that are still lucky enough to still be here and are long term – life time users.
Shared care approach / transition period
At first I found it a bit strange, as I felt my support group i.e. clinic staff, were no longer available to me (although I could have contacted them if I needed to) and maybe the transfer from one to the other could be a bit more gradual or help clearly made available, maybe even ring counsellors once a week.
I would like to comment about accompany on first visit to GP. It's very necessary if the client and the Dr do not know each other as I've heard of some very sorry cases (previously ran a needle exchange).
I thought I'd get more privileges but not at all, the rules and protocols are the same.
Education
Education of clients
CADs patients need to be made aware that moving to a GP programme is a 'POSITIVE STEP' towards moving on in life – AS I DID
Take away insecurity (verbal communication with current patients on GP programme). More likely to listen and believe. If not 'secure' first – won't work!
Knowing prior that the GPs are helpful and care and respect their patients is all important.
Education of GPs and support staff
Doctors need to have proper training though, I know mine did
More GPs need knowledge (or did when I chose years ago).
In my experience the GPs that join the programme are generally empathetic and treat their clients very well. They tend to have done research into addiction and have an interest. Many non-programme GPs seem fearful of it.

QU 10a IF 'QUITE LIKELY' OR 'VERY LIKELY' THAT YOU WILL TRANSFER BACK TO THE METHADONE SERVICE, PLEASE STATE BELOW THE REASONS WHY YOU ARE LIKELY TO RETURN

Financial – cost is a barrier
I have thought about it as I had to get a loan through instant finance on a doctor's bill which now I'm paying back at 33% interest. I've been told that my liaison officer feels it would be a step backward so I'm not sure.
It's free [AMS]
Flexibility to transfer between services
The only reason I would return is if I found myself using illicit drugs again
And/or felt my health, mental and physical, was at risk. The counselling at the clinic helped me through and early rough patch.
I didn't know it was an option
Fear of Unknown
I'm scared to change my situation in case it causes problems.

4 Thematic analysis: GPS

QU.9: WHAT ELSE DO YOU THINK COULD BE DONE TO ENCOURAGE MORE PATIENTS ON MMT TO TRANSFER FROM SECONDARY (SPECIALIST) TO PRIMARY HEALTH CARE?

Financial
Cost is a barrier
Cost can be an issue (free for CADS) but this applies to all 1st-2ndary service transfers
The fee issue is a big stumbling block
Problem is not necessarily the patients on MMT as I have several that would like to transfer, but I am unwilling to expand due to the extra time involved and the lack of remuneration as they have high outstanding accounts
To have proper funding for providing services, as I find they are poor payers and require a lot of extra care
I only have one patient on MMT but occasionally am involved with patients other doctors have in practice – invariably they owe the practice large sums!
To have proper funding for providing services, as I find they are poor payers and require a lot of extra care
Discussion over fee structure with potential GP (e.g. I tend to discount) emphasising the importance of primary health care (e.g. other health care needs)
The fee issue is a big stumbling block
When you take on MMT patients you know you won't get paid.
Modification of Current Funding System
Pay the GP (not ??? patient)
Pay for their visits
If they get some financial help towards seeing their GP
The 'Care Plus' scheme to encompass MMT patients, with the PHO practitioners 'bulk funded' for them
Agree to up to a ceiling of $150 per three months for doctors bills
Funding their visits to the GP, taking away that barrier which may be a significant one for some patients
Help with fees, disability forms from WINZ etc.
Taking a harder line: frankly I have been concerned that the legislative wish that 50% of patients be under GP care has been subconsciously wasted by the clinics need to retain its patient base to obtain finance (there is no other service in which patients can obtain such care indefinitely free of charge)
Look at other ways of meeting fees. Ie. Through Procare, DHB, government, WINZ
Some financial help to patients
Have some monetary contribution to the GP care
The usual patients who run up accounts are those who still attend CADs for methadone (a free service, so why shouldn't the GP be free?)
Pay the GP more on top of usual consultation fee already paid by patient
Offering them help with fees at GPs
Assistance with cost of therapy
Subsidisation of GP visits to minimise cost issue
PHO subsidies for patients on MMT
Subsidy for GPs
Reducing fees at the GPs with extra subsidy

To have proper funding for providing services, as I find they are poor payers and require a lot of extra care
Pay for their visits to GPs
Nature of General practice/patient relationship
Stigmatisation of Clients (+ and -)
Problem when other staff in practice not supportive. Preconceived ideas from receptionists, nurses etc.
One person for all healthcare needs
Concept of holistic approach to health.
Discussion over fee structure with potential GP (e.g. I tend to discount) emphasising the importance of primary health care (e.g. other health care needs)
Move from specialist to mainstream health service
Patients I talk to are keen to transfer and are usually stable. Stability and readiness to transfer seem to go hand in hand.
Have good relationship with GP
In my experience patients prefer primary health care – more personalised service, works efficiently.
Negative client behaviour
I only have one patient on MMT but occasionally am involved with patients other doctors have in practice – invariably they owe the practice large sums!
The group of patients I have under my care have all been cooperative and pleasant to deal with. One exception 3 yrs ago was referred to the methadone service as being unreliable difficult and often out of control.
The problem we have is that in a small community it is obvious when patients misuse their supply, and several deaths attributed to methadone resulted in community pressure not to be involved in supply.
Also, stand over tactics and aggression can be very unsettling
GP 'Stepwise' process
Development of contract of care
A contract with the GP on the first visit
Strict criteria re: new/changing/lost scripts and changes of collects spelt out + 'contract' signed before transfer – would encourage more GPs to take MMT patients too.
A brief one page sheet outlining the practical logistics of GP methadone prescribing sent to the GP to sign to say they would be prepared to do this. After it is sent back it should be shown to the patient as evidence the GP is okay with the requirements.
Advice re: each individual GP's 'rules' in the practice (ie appts/payments etc.)
Shared care approach / transition period
Discharge them from MMT with an agreed overall plan/vision of long term (years) treatment. Some patients keen to reduce, others prefer to stay on maintenance. This gives provider (GP) and patient a framework to continue with.
Plan a review 3-6 months after transfer for reassessment
Education
Education of clients
More general info (from MOH) about the PHOs
Educate them regarding GP services and their commitments with their doctor, practice nurse and chemist
Educating and relieving any fears they have of doing so
Education about GP being an advocate who won't judge them on reasons why they are on MMT.
Education of GPs and support staff

Better education of primary care doctors on methadone treatment, and better understanding of problems associated
Encourage GPs re the validity of this programme
Explain to GPs that all these patients are not a hassle and difficult
Explain to GPs that a patients becoming difficult can be returned to AMS
Handbook to GP (already provided)
Educating GPs leading to changed attitudes – targeting registrar/seminar attendees?
More education for GPs
Explain to GPs that a patients becoming difficult can be returned to AMS
Other (miscellaneous comments)
I wouldn't want very many patients on methadone, and only in special circumstances. E.g. I already know the patient, or some intermediary, and the patient is aware of the special privilege and responsibilities to the GP.
Encouraging the development of the GP role ie have a smaller number of GPs with a special interest developing bigger practices.

Appendix E: Indicators of MMT stability / instability

Transfer to normalisation of treatment in the community is an expected client pathway for the client who is assessed as stable in methadone treatment or, for a client who is assessed as suitable for a shared care GP arrangement. The following indicators of stability and instability have been obtained from the Auckland Regional Methadone Services (ARMS) Philosophy Policy Protocols.[31]

The following indicators may be considered when determining client stability / instability:

Indicators of stability

- No problematic, harmful or hazardous use of alcohol or drugs
- No evidence of criminal activity
- Responsible management of takeaways
- Schedules and attends appointments
- Rarely requests changes to dispensing
- Social stability as evidenced by relationships with others, stable and healthy housing, employment/occupation
- Any co-existing mental or physical health problems are well managed
- Participates in primary healthcare
- Complies with programme requirements.

Indicators of instability

- Problematic, harmful or hazardous use of alcohol or drugs
- Engages or supports criminal activity
- Signs of intoxication at clinic or pharmacy
- Evidence of intravenous injecting

- Irregular dosing
- Poor attendance at appointments
- Avoidance or urinalysis or blood tests
- Behavioural problems such as aggression
- Frequent requests for changes to dispensing
- Requests to replace lost or stolen doses
- Any co-existing mental or physical health problems are difficult to treat or are not well managed.
- Does not have or will not identify a GP.

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