The Methadone Treatment Protocol in Ireland

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Background

The opiate problem in Ireland was first acknowledged in the early 60s and a single treatment centre was established in Dublin to meet the needs of a small cohort of patients. During the 70s, there were a number of political attempts to deal with the “drugs” issue – but these were based mostly on the criminal rather than the health aspects of opiate addiction. Treatment services were based mainly on abstinence with virtually no methadone maintenance treatment. With the arrival of HIV in the mid 80s, there was a move to develop harm reduction programmes.

In the early 90s, international evidence supported the notion that a high quality, holistic service could be provided to addicts at the primary care level. Accordingly, a task force was established by the Irish College of General Practitioners to draw up a blueprint for how services should be developed. With an estimated 13,000 opiate addicts in 1996, and less than 5,000 of them receiving treatment, it became increasingly obvious that treatment services needed to be expanded. The Department of Health and Children convened an expert group consisting of key stakeholders (representatives from the Irish College of General Practitioners, the Pharmaceutical Society of Ireland, Specialist drug treatment services, the Department of Health and Children and the Eastern Regional Health Authority). The Methadone Treatment Protocol (MTP) was developed from the 1993 blueprint.

The Methadone Treatment Protocol (MTP)

The principles underlying the MTP are:
- The regulation of methadone prescribing and dispensing in primary care
- The development of close co-ordination between primary and specialist services
- Training and regular, structured review for service providers.
The essential components for tackling opiate addiction were identified as being:
- Bringing about changes in the attitudes of both the public and service providers through education
- The development of adequate structures for the delivery of healthcare in areas of high deprivation where opiate addiction is found
- The regulation of methadone and benzodiazepine prescribing.

A national GP co-ordinator, Dr. Ide Delargy, was appointed and the programme was launched in October 1998.

**Structure of the Methadone Treatment Protocol**

While the opiate problem is primarily concentrated in and around Dublin, our capital city, the protocol was introduced nationally. The rationale for this was that opiate misusers could migrate to other parts of the country if methadone were more easily accessible outside Dublin and this would likely result in relatively inexperienced doctors being pressurised into prescribing for addicts. Consequently all doctors and pharmacists involved in treating addicts with methadone must legally be part of the new scheme.

The programme is based in primary care with each patient registering with a named general practitioner and a designated community pharmacy. A central, confidential database of all patient receiving methadone is maintained by the Eastern Regional Health Authority on behalf of the Department of Health and Children. This allows for cross-checking to minimise the risk of duplicate prescribing by another practitioner. Once entered on the central register, each patient receives a credit card-sized laminated card with patient details including photo ID. The card also lists the name and address of both the prescribing GP and the dispensing pharmacist. The card is held at the pharmacy until treatment is complete. A unique prescription form for methadone prescription is issued to participating GPs.

**Service Providers**

**GPs – Level 1:** Level 1 doctors look after stable opiate addicted patients who have been deemed suitable for methadone maintenance in general practice. They will have been stabilised at specialist drug centres. Doctors at this level are confined to treating a maximum of 15 patients.

**GPs – Level 2:** Level 2 doctors are capable of making a full assessment of a drug misuser. They must have the necessary skills to stabilise and manage the ongoing care of drug misusers. GPs at this level are permitted to treat up to a maximum of 35 patients.

**Training Requirements**

The training requirements for level 1 doctors are:
- One day training programme
- Annual external audit
- Annual update seminar
The training requirements for level 2 doctors are:
- One year at level 1 with a minimum of 10 patients
- Two day training programme
- 10 clinical sessions with an accredited level 2 GP
- Quarterly continuous medical education meetings
- Annual external audit.

Training is devised and provided by the national GP co-ordinator through the Irish College of General Practitioners. It is funded by the Health Boards, the regional bodies responsible for the planning, organisation and implementation of healthcare. An education review group, representing the key stakeholders, oversees training, clinical standards and the audit process.

**Patient Participation**

The total number of addicts officially in treatment has increased since the introduction of the MTP from 3,350 in October 1998 to 4,499 in April 2000, eighteen months after the introduction of the programme. The number of patients transferred from specialist drug treatment services to primary care has increased from 1,042 in April 1999 to 1,456 over the same period. 95% of primary care-based patients are registered with GPs within the Eastern Regional Health Authority area (the area centred on Dublin).

**Service Provider Participation**

At the introduction of MTP in October 1998, there were 90 GPs involved in prescribing methadone on a regular basis. Six months after its introduction (Apr 1999) the number of GPs with patients at level 1 had increased to 135. Eighteen months after introduction (Apr 2000) the number of GPs with patients at level 1 is 160. Two hundred and six doctors have received training at level 1 to date. Seventeen have been accredited at level 2 with a further 20 in training.

In October 1998, 145 pharmacies were dispensing methadone. This had increased to 180 by April 1999 and 208 by April 2000.

**Outcomes**

**General:** All participants in the programme report a high level of satisfaction. The number of addicts in treatment has increased steadily over the two years, with an increasing proportion being treated in primary care. Currently, one third of all addicts are managed in primary care. Outreach workers and patients report less methadone making its way onto the black market. The Gardaí report a reduction of 60% in crime figures. We know that a significant proportion of crime is drug-related and this reduction is consistent with international evidence showing a reduction in crime when a comprehensive methadone treatment programme is available. Almost 40% of addicts being treated in primary care have returned to work.

**Formal evaluation:** All participating GPs have recently been surveyed. A patient satisfaction survey is currently in progress.
GP Satisfaction Survey

There was a 73% response rate to the GP satisfaction survey. Results show a high degree of satisfaction with the programme.

Professional skills
- 83% feel their management of opiate misusers has improved since the introduction of the programme.
- 85% say they are now more likely to take patients on methadone treatment.
- 83% feel their understanding of addicts has improved.

Operational issues
- 94% have found urine screening easily accessible.
- 73% of those with a problem found it easy to refer a patient back to the specialist services.
- 97% believe that the methadone dispensing arrangements have improved.

Training programme
- 93% were satisfied with the training programme.
- 74% found the national GP co-ordinator a useful resource.

Interim assessment

It seems reasonable to conclude that the introduction of the programme has been a success, despite some initial scepticism.

The particular advantages of the Irish system are that it is a national programme with contractual obligations including ongoing training and external audit. The system also encourages and facilitates the ready transfer of patients between the specialist services and primary care as appropriate. This is of benefit to all as the specialist services are enabled to provide specialist care for difficult cases with the transfer of stabilised addicts to primary care. GPs are given the opportunity to provide holistic care for stabilised addicts within a programme that provides appropriate educational support and ready access to specialist services as the clinical situation demands.

And, most importantly, the patients have benefited. This programme facilitates normalisation of their interaction with the health services where their entire healthcare needs can be addressed by their GP within their community.

Future Plans

The MTP will be expanded to include more interested GPs and CPs. It is envisaged that all routine methadone maintenance will take place in primary care, reserving more specialised units for the care of cross-addicted, psychiatric or violent patients. The audit process will be further refined. Having ensured that minimum standards are being met by all participating GPs, a more detailed analysis of the quality of care being provided is planned.
Joint ongoing training for GPs and CPs will be explored.

A distance learning programme is being prepared and will shortly be available on CD-rom. It is targeted at level 1 doctors and will facilitate doctors throughout the country to participate in the training programme.

An educational module has been developed to introduce medical students to the health and social problems experienced by drug misusers. This has been introduced in one of the five medical schools in the country at present. Working to an agreed curriculum, students visit clinics and surgeries where services are provided to drug misusers. A pre/post-intervention attitudinal study is ongoing.

**The Way Forward**

Many of the essential components in improving the care of opiate addicted patients are being integrated. The main area that remains to be tackled is benzodiazepine prescribing. The Department of Health and Children has convened an advisory committee to address the issue of unregulated benzodiazepine prescribing. This committee has just recently begun its work. It believes that it is the joint responsibility of GPs and CPs to ensure that benzodiazepines are dispensed safely and responsibly. An audit of the extent of careless prescribing is to be undertaken, in the first instance. Good practice guidelines will then be developed to include strategies for managing long-term benzodiazepine users and for handling new requests.