

Methadone Treatment in Irish General Practice: Voices of Service Users

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Abstract

This study sets out to make a meaningful and useful contribution to the discussion surrounding the treatment of heroin addiction in Ireland. The study took place in nine urban general practices in Dublin city. Twenty five service users were interviewed in-depth. A phenomenological approach drawing on the psychological research methods of Colazzi for data analysis informed this study. Four themes emerged from the data: Service users' the significance of methadone for the service user; service users' understanding of the Methadone Treatment Protocol and the experience of addiction and its effect on families.

This paper reports on the experiences of service users receiving methadone treatment in urban general practice in Dublin and in so doing highlights the influence of the GP in supporting recovery. It explores the theme - Service User's Experience of attending general practice for methadone treatment. These accounts provide insight into the harm reduction policy of methadone maintenance and highlight how - from the service users' experience - the implementation is falling short.

Introduction

Heroin addiction is a chronic relapsing condition and GPs have a pivotal role to play in the care of patients receiving treatment with methadone.^{1,2} In Ireland, the prescribing and dispensing of methadone for problem opiate use has had a formal legislative basis since 1998. The format for both how methadone is regulated and how opiate dependent patients are managed is commonly known as the Methadone Treatment Protocol (MTP). There are approximately 8,000 to 10,000 clients receiving methadone, although numbers can fluctuate, and of these almost one-third (32%) currently prescribed methadone are cared for in general practice.^{3,4} Methadone treatment is also provided by the National Drug Treatment Centre (NDTC), Health Services Executive, addiction clinics and satellite community clinics.

The GP's unique knowledge of the patient and their extended family can make a considerable contribution to the long-term management of these drug using patients. To facilitate this the Irish College of General Practitioners (ICGP) provide Level One and Level Two training in methadone treatment for GPs.⁵

It is recommended that doctors when completing their training in general practice should have received Level 1 training, which provides the foundation for treating stable

methadone maintained patients in general practice. Stabilisation usually takes place in a health board treatment centre but may also be offered by a suitably trained GP colleague (Level 2). A Level 2 GP may initiate treatment, stabilise a drug misuser and provide ongoing maintenance treatment in the primary care setting.⁵

Historically, there is little evidence that the needs and wishes of Irish service users have been actively sought in this treatment programme, although users' views and experiences with methadone treatment have been investigated internationally.^{6,7,8,9,10,11} Studies demonstrate that client perceptions have been assessed across a number of treatment domains, including the clinic environment, service provision, clinical relationships, medication and treatment outcomes. Although a comprehensive approach to user's individual needs has been advocated internationally there is still little evidence to support the effect of user involvement and decision-making in drug services.^{12,13} User involvement has been relatively slow to develop and there are differing opinions as to how user involvement impacts upon service delivery.¹⁴

Service providers, however, have been investigated and recent studies have focused on the attitudes of GPs. A postal survey of 600 GPs on the ICGP drugs misuse database explored current attitudes to the MTP. Of the 600 questionnaires sent, 207 responses were received (a 34.5% response rate). The majority of respondents (72%) already had patients on the MTP. Attitudes which focused on the benefits of methadone treatment suggested that GPs overwhelmingly believe that it is an essential service to drug users (95%) and the majority (96%) felt the structure of the MTP provided a regular opportunity to review patients' progress allowing a good relationship to develop. This survey reflected the views of those who are interested in methadone treatment and bias can not be excluded due to the poor response rate (34.5%) and the fact that all those surveyed had participated in ICGP training.⁴ In the absence of other research, this survey was useful for gaining cautious insight into the recent attitudes of GPs in Ireland.

There has, in contrast, been limited experience in either encouraging or investigating drug user consensus viewpoints. A culture of user involvement is underdeveloped, although it is recognised that it is essential to service evaluation and development.¹⁵ When reviewing the literature for the National Strategy for Service User Involvement in the Irish Health Service, McEvoy suggested that some of the most provocative and intelligent discussions on service user involvement are to be found in literature that is outside the usual parameters of scientific

databases.¹⁶ Small studies such as these which exist in Ireland portray largely negative reactions of service users to treatment programmes and also negativity in relation to service provision.^{17,18,19,20,21,22} These studies - although involving service users - were not carried out exclusively in general practice and did not explore the issues in detail.

Thus there has been a serious lack of debate in relation to service users' views and the evaluation of this treatment modality, and to this end the views of those receiving methadone were considered an important investigation. This study was undertaken against a background of little qualitative work on the lived experience of those attending general practice in Ireland and none that explored methadone service users' perspective of their treatment solely within this environment. Alternative perceptions had not been addressed and the significance of exploring the insight and understanding of service users' experiences had been markedly absent and indeed overlooked in previous studies. It was uncertain if discrepancies existed between what the MTP advocates in general practice and the reality of the situation for the drug misuser. It was also unknown whether partnership in treatment existed between the treatment provider and service user. Actual care versus ideal practice -one of the recommended avenues for research advocated by the ICGP research strategy (2003 to 2008) needed to be investigated and highlighted.²³

The aim therefore was to explore how the MTP was being implemented in general practice from the perspective of the service user, including the following objectives:

1. To describe service users' lived experience of the MTP
2. To discover the shortcomings and benefits of experiencing methadone treatment in General Practice in Dublin
3. To describe service users' experience of being involved in decision making and management of their treatment, and
4. To identify the steps required to address any limitations or deficiencies in treatment by considering the perspective of the service users in the context of current practice.

This paper expands on the first two objectives.

Methods

The goal of qualitative research is that theories or hypotheses are not established 'a priori', and imposing hypotheses on the experience of service users would not have been consistent with the research question posed.

The design of the study was within a qualitative model which utilised the methodological strategy of phenomenology. Phenomenology has been described as a philosophy, an approach and a method that possesses a reverence for experience that is useful when the focus of inquiry is narrow (experiences of methadone treatment) and the respondents represent a clearly defined and homogenous unit within an already known context (urban general practice within Dublin).^{24,25} Guided by this research epistemology it was considered possible to emphasise and describe service user's experience of treatment. The choice to use a Husserlian approach was based on the focus of the study, which was descriptive rather than interpretive. Descriptive studies are sometimes the only practical way of studying some topics in drugs

Gender - Cases by Attribute Value

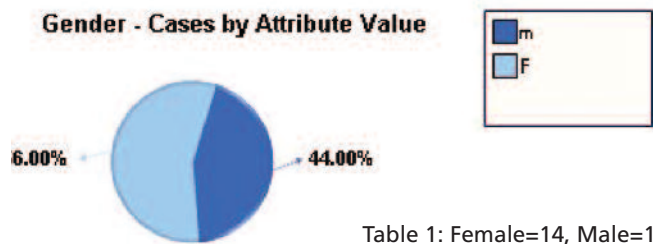


Table 1: Female=14, Male=11

Age - Cases by Attribute Value

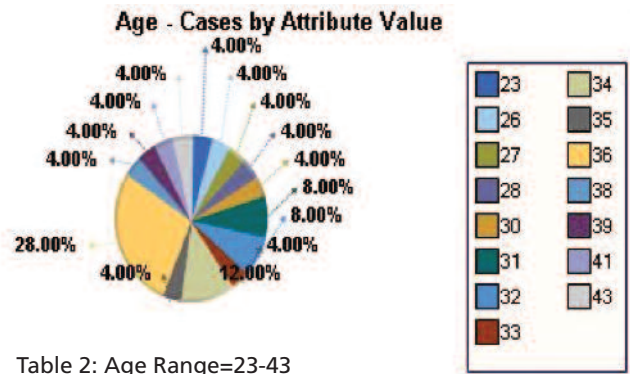
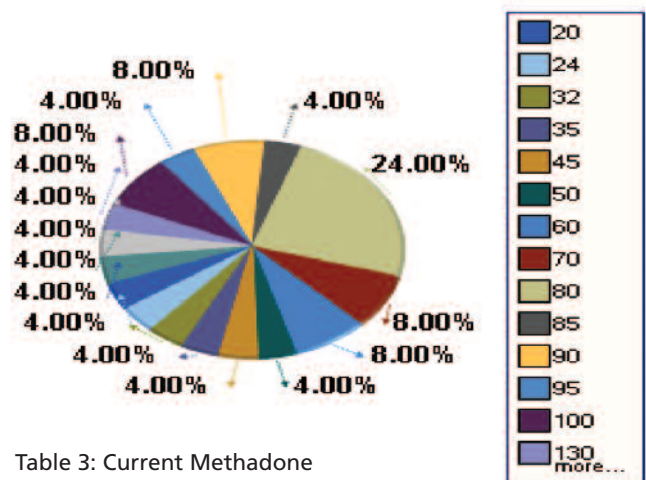


Table 2: Age Range=23-43

Methadone dose - Cases by Attribute Value



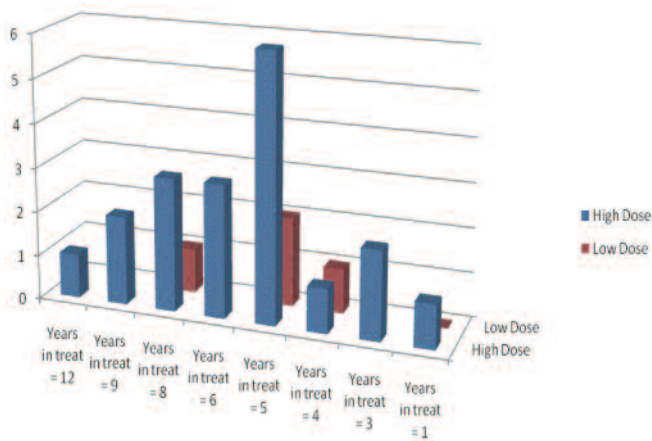


Table 5 Years in treatment and methadone dosage

Low Dose Defined as 40mgs or lower
 High Dose Defined as 45mgs or higher

Whereas some participants ran against the trend (low years/ high dose or high years/ low dose) this graph clearly shows a consistent pattern in the data. That is, a clear relationship between the length of time in treatment and the dosage of methadone with patients in treatment longer being prescribed higher doses.

research and are helpful as they are thought provoking and can suggest further questions that can be investigated using a different approach.

The study was divided into Phases 1 and 2. The pilot phase of the study (Phase 1) was conducted from November 2007 to April 2008. During the pilot phase three respondents who were considered to be 'key informants' were interviewed. Methodological, conceptual and pragmatic lessons were learned from a preliminary investigation of these service users receiving methadone in two general practice sites. Both the researcher's practice and another practice were used exclusively for the pilot phase. Two of the informants were actively involved in service users groups and education of drug users in their respective communities. The third had been treated for many years in several different services, including treatment clinics. The method of using two researchers proved to be effective for both comparing and contrasting interview styles, and testing the methodological approach of phenomenological interviewing which proved apposite for the study. Three main outcomes from the process of piloting were: identification of a sampling methodology, preparation of site and the development of a topic guide.

The sampling methodology was purposive within a maximum variation sampling strategy as advocated by Patton's typology.²⁶ It was considered that identifying service users who were receiving treatment for longer than one year would more adequately reflect continuity of care in general practice.

The preparation of site was facilitated by three GPs who gave guidance on the framing of the approach to GPs. A simple letter was sent to all the practices outlining the process, together with a step-by-step guide to enable a streamlined approach to recruiting participants.

The topic guide was piloted and then reshaped and refined following each of the pilot interviews until a desirable dialogue was facilitated for Phase 2 of the work. The interviews were characteristic of phenomenological research – they were in-depth, open-ended and facilitated accounts of meaningful culturally salient responses. Topics for discussion were, for example, ascertaining the service users' answers to the question, 'What is it like attending a GP for methadone treatment?'

For phase 2 of the study the following criteria for selecting service users was utilised after reflecting on the process of the pilot study.

Inclusion criteria

Those willing to participate and provide informed consent, i.e. stating no coercion or incentives were offered.

Level 1 and Level 2 participants. Those who attended a doctor qualified to treat at Level 1 (i.e. stable patients), and those who attend a doctor qualified to treat at Level 2 (i.e. less stable patients).

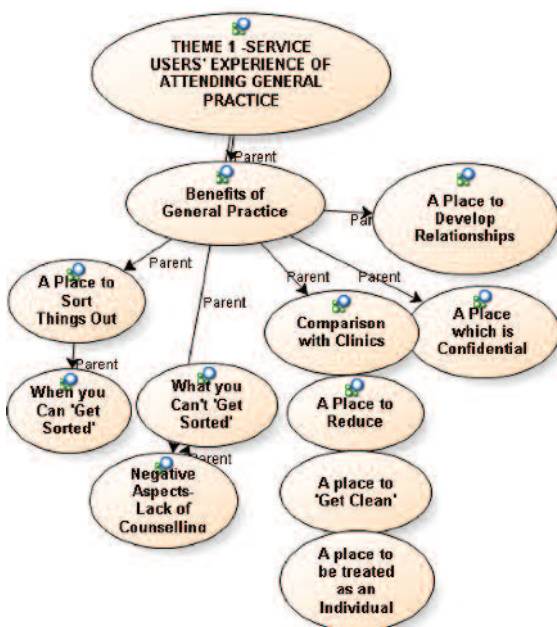


Figure 1: Theme 1 Service Users' Experience of Attending General Practice

Exclusion criteria

Those who refused to be involved.

Those experiencing severe psychiatric co-morbidity, as assessed by their own GP.

Users under 20 years of age as MTP is not encouraged as first-line treatment for adolescents, and they are not generally in treatment in general practice.

As the actual sampling and recruitment took place in the field, potential respondents who fulfilled the sample criteria and the overall sampling strategy were dependant on invitations issued by the GP. This meant that recruitment was subject to 'the gatekeeper syndrome'.²⁷ The insight of the GP was paramount to effective recruitment as they could attest to the suitability of the co-researchers' abilities to engage with the process. Each GP identified service users whom they considered had sufficient experience of the research topic of methadone treatment. The GPs also required that the service user have the capacity to provide full and sensitive descriptions of the experience under examination.²⁸ This method of respondent recruitment was effective but not without difficulties. In total the sample comprised 25 participants who were registered with their GP for methadone treatment. These were recruited from nine general practice sites in Dublin. Both Level 1 and Level 2 GPs were approached. The same general practice sites where access was previously granted in 2003, in addition to the independent pilot site, were utilised, building on the researcher's previous study exploring The Perceptions and Experiences of Practice Nurses in Relation to Patients on a Methadone Treatment Protocol.²⁹

Not everyone approached to take part agreed, particularly as the length of the interview (indicated in the participant information leaflet) proposed an hour. The refusals were possibly not related to the research topic but rather the length of time required for the interview. Some clients agreed to participate on the morning when they were attending the GP but refused when they had collected their prescription as they said they were rushing to the chemist for their methadone. Others promised on many occasions to attend for interview but did not turn up despite reminders. Deficiencies and biases in the sample were avoided however as there was a sufficient pool of respondents in each practice to provide a sufficient sample based on a maximum variation sampling strategy.

Data analysis

The psychological research methods of Colaizzi informed this study and the data were analysed using the methodology he described.³⁰ Initial reading of all the transcripts to acquire a feeling for them was followed by Colaizzi's steps to produce a structural definition of the findings.

- 1) The transcribed interviews were read thoroughly so that the researcher became immersed in the data (comprehending). Each transcript was imported into the software package NVivo8, assigned to its own identifying folder and linked to the participant's voice which could be accessed and listened to simultaneously throughout the process of analysis.
- 2) Significant statements and phrases directly related to

methadone treatment were identified and transformed into the words of the researcher. This was the first step of preliminary coding. This was expressed as individual free nodes.

- 3) The researcher attempted to spell out the meaning of each significant statement (synthesizing). These statements reflected the essential point of the selected text.
- 4) Significant statements were collected and organised into further clusters of themes (theorizing). This was the second step of coding expressed as tree nodes in NVivo8.
- 5) The individual themes were then clustered to produce a further reduction into general themes that were common to all the subjects' transcripts. These themes were further broken down from tree nodes to what NVivo describes as 'child nodes'. Tree nodes can have 'children' as such and thereby have a hierarchy on these synthesized statements imposed on them.
- 6) The researcher then returned the transcript to the participants (18 wished to read their interview) in order to confirm that it accurately reflected the essence of their lived experience, therefore enhancing the trustworthiness of data. Two service users expressed literacy difficulties as a reason for not reading the transcripts. Any relevant new data from telephone follow-up interviews were worked into a revised final description (15 responded to telephone calls). The researcher moved back and forth between the meaning statements and the revised lists until the themes were accurately reflected in the clusters. The final result of the zig-zag process was the finding of the research, i.e. the overall description of the experience which is the essential structural definition.

One further step, which Colaizzi did not carry out, was to calculate the percentages of the occurrence of statements across the transcripts. This further progression in the analysis was aided by NVivo 8, which also provided an auditable account of the research process of both data collection and analysis.

Results

Four themes were identified: Service User's Experience of attending general practice for methadone treatment; the significance of methadone for the service user, service users' understanding of the MTP; the experience of addiction and its effect on families.

This paper explores the theme – Service users' experience of attending general practice for methadone maintenance.

There were 106 significant statements from 23 sources which pertained to the service users' perceptions of the benefits of attending general practice. The transformed meaning was further broken down into distinct meaning units, which were attributed to the lived experience of service users in general practice as opposed to the experience of attending a treatment clinic. There were 84 references from 22 sources relating to clinic services. The overall description of the experience in general practice was described by the majority of service users as a comparator to past experiences within treatment clinics. Although no specific question was asked about the treatment clinics the experience featured highly in the majority of service users' experience. Key aspects of attending general practice were identified as: a place to be treated as an individual, a place which is confidential, a place to get clean, a place to reduce, a place to develop relationships and a place to sort things out.

Descriptive statistics: Age range was from 23-43 with 14 female and 11 male participants. Nineteen of the participants were parents and the majority had two children. Eighteen had achieved either the Irish academic qualifications of Junior or Group Certification and six had completed their junior certification. Five females and five males knew they were HCV (Hepatitis C) positive. Current methadone dose ranged from 20-150mgs/per day. Those patients in treatment longer were receiving higher doses. Years in treatment ranged from one to 12 years with the majority in treatment in general practice for more than five years. The nine practices visited for the purpose of the study were well-equipped surgeries with secretarial support, IT facilities and all had the services of at least one if not two practice nurses. There were 13 practice nurses, 42 GPs and 487 methadone patients registered with these nine practices (by self assessment). The combined practice lists were approximated at 270,000 patients.

Male to female ratio showed a majority of male GPs. There were a sufficient number of female GPs to ensure anonymity in mentioning their gender. The use of pseudonyms provides anonymity in the following extracts from service users self-report.

A place to be treated as an individual

General practice was consistently described as a "different place". There were 31 significant references from 15 sources identifying the importance of being treated as an individual in general practice. The word 'place' was mentioned 114 times and 'different' 195 times. It is important to highlight that frequency of occurrence of references does not equate with social significance of the topic but is useful for the purpose of transparency and reader information. The majority of service users expressed their preference to be treated in general practice. In the following descriptions the service users describe the difference.

Daithi: "...but in a clinic ...cause they treat you all the same, you see they see so many drug addicts in there that they paint them all with the same brush you know."

The experience in general practice was highlighted as different.

Craig: "you're not treated... here [in general practice] you're not... they don't treat you like you're an outcast."

Sean: "eh, the dread of going down there, [Treatment Clinic] the way you were treated, to start first of all by the security guards going in like you would be going in there day after day after day. (General Practice) Much different, much difference, much more friendly eh which makes it much more easier for me to open up and tell you if I've had a slip or tell you if something has gone wrong or whatever, you know?"

These accounts emphasise the institutional environment of the clinic, and the highly regimented mechanisms in place for managing security.

A place which is confidential

Service users spoke of valuing discretion and confidentiality and spoke positively about the assurance general practice afforded them in the patient/GP consultation:

Rhiana: "I find that it's more private, you know, people don't know your business because you can be here for anything like? the 'flu, whatever you're here for, you feel normal."

Padraig: "What happens here stays here you know what I mean? It doesn't go any further."

Attracta: "It's not a drug treatment centre, like it's a doctor's surgery but like nobody knows what you're here for. They knew exactly what you were coming and going for [in the treatment clinic]... you're not picked out ...you're not just fingered cause you're... it's your normal GP do you know what I mean?"

A place to get clean and a place to reduce

There were 36 references from 18 sources describing how the treatment clinic had never been perceived as a place to become drug-free in contrast with general practice. The following descriptions focus on the importance of treatment context, as general practice is viewed by the service user as a place to "get clean". This place was described as a setting where it is possible to have a plan to separate from the environment of attending a treatment clinic and the peer pressure exerted by other drug misusers, which is inevitably a deterrent to becoming heroin free.

Sean: "People nowadays and going back years, they never seen (the clinic) as a place to get clean... People stand around outside offering you drugs, offering this, so you have none of that (in general practice) and that is a good thing."

The importance of the treatment setting is a perspective shared by professionals, as the following extract describes:

Erica: "I think I was only down about a year and, ehm, the doctor down there (in clinic) he was kinda saying because there was a lot of stuff going on outside after the clinic, you know? Swapping things and selling the stuff ...and he said to me, you will start doing stuff if you stay down here and he said he would try Dr. X as he said he would try and get me a GP in the area."

There was verbal evidence that the aims of the ICGP guidelines in relation to encouraging reduction strategies and supporting maintenance were being implemented by the majority of service providers. General practice was identified as being potentially beneficial in two important aspects of treatment - reduction in dosage of methadone and control over treatment. Meaning units derived from 112 references obtained from 24 sources described the treatment context as a place to reduce.

The experience of those who were reducing their dosage or had a

plan to reduce is described in the following extracts:

Sibh (dosage:32mls): *"I'd never been where I am today only for coming here. I was on 80 mls and they wouldn't let me come down (in clinic)...and I wanted to come down. And I came here (general practice) and they gradually have done that now in the four years that I have been here."*

Sean: *"I will work myself right down to the two [mls] and then I will stop."*

The ICGP guidelines advocate that once a level of stability has been reached the patient may wish to consider working towards abstinence by slowly reducing their methadone dose over time. The advantages of reductions in methadone when on maintenance can be planned and each successful step helps to reinforce progress and boost self esteem (ICGP2008:21).

A place to develop relationships

All service users described the doctor/patient relationship and 182 references to the concept of relationship were made from the 25 sources in the study. There were voluminous data and these responses were further broken down from tree nodes to child nodes, which identified both positive and negative experiences. Overall, 100 references from the 25 original sources indicated that although there were some negative experiences in relationship building the overwhelming picture was that general practice provided service users with a place to develop relationships and the majority acknowledged a good relationship with their own GPs.

The following descriptions emphasise the importance of the relationship.

Seamas: *"I've known him (GP) that long like we seem to nearly grow old together like... so it seems like ... we've grown up together in a different way you know... I've been here probably 15 years with him,...I wouldn't see anybody in the week or the only person I'd see would be Dr X I call him [Christian name] and I actually felt a lot better walking away like he does... he's a caring man."*

Niamh: *"...he [GP] knows by looking at me, I have to say I have a great relationship with the doctor."*

Researcher: *"... tell me what that means like what does a great relationship mean?"*

Niamh: *"like I can come in and say to my doctor look it I'm just f**king pissed off, what the f**k is wrong with me? I'm like a bull all the time you know? and I ... But I think he actually appreciates me doing that and being honest with him you know?"*

The majority of service users described the personal relationships with their doctors and being listened to as in itself "a cure". They described a repeated consultation pattern with the GP who knew them. This relationship involved being listened to, being heard and valued, in other words a therapeutic relationship.

Daithi: *"Oh no, no, I wouldn't be here otherwise, on me life, I've built up the trust now the doctors you know I could come in here and talk to them about basically anything and they're genuine they listen to me ... I come in here and you'd talk and he would listen to you, to me and another time you just want to come in to talk like and you'd be listened to."*

There was evidence however that potential existed for two very different types of relationships to develop when the service user attends their GP for treatment. There were three accounts where service users identified negative experiences and a different consulting style. The term 'phy doctor' (Physeptone) was used and contrasted markedly with the consulting style of the majority of the other GPs. These service users perceived the GP to have a lack of interest in their emotional well-being.

Sean: *"Some doctors they come in they get the sample they look at it yeah, grand right there's your script... go! You know what I mean? Out!"*

Olwyn: *"...things definitely have changed since... I've become his methadone patient ...I go in the door now and automatically it's just, check me urine and he's writing out a prescription and he's trying to get me out the door as quick as possible ... yeah like all he is to me, now phy to mewrite it down ...push it across see you next week... yeah he just automatically assumes that once you're come in you're coming in for your phy prescription and nothing else...you just get to see a 'phy' doctor now."*

Researcher: *"...would you just think that what you say is important to her?"*

Helen: *"No, no because [doctor] is just.... this is what [doctor] does [mimics looking down at prescription pad] oh what are you on again? I say 80 and what day are we? Ok, ok there it is, come back to me, six weeks, now there it is!"*

A place to sort things out

The general practice experience was sought after as a place where the children of service users attended and were able to 'sort things out'. Services availed of were described as care for minor illness, child health, women's health (smears and coil insertion) asthma checks, health promotion (including weight reduction, advice on hyperlipidaemia, phlebotomy and viral screening), infertility, antenatal, pregnancy and post-natal care, blood pressure monitoring, flu vaccinations, childhood vaccinations and managing depression and back pain.

Niamh: *"It's a place where you can bring your kids."*

Ken: *"Yeah, I have me own time you know what I mean, I have me own time to come in and sort things out."*

Not all participants had these experiences of service provision. There were 59 references from 19 sources describing counselling facilities and the perception that there was a general need for this in general practice.

There were idiosyncratic responses as to whether counselling was considered necessary by the service users although there was evidence that the location of the psychological care that was offered did matter as three of the interviewees were able to access on-site services. Accessing on-site addiction counselling at the same time as visiting the GP was described as:

Craig: *"I'd rather that time kill two birds with the one stone."*

Even though the relationship with GPs was considered to be good it was considered by all who described their experiences that counselling was a service which met a specific need whether the service user wished to attend or not. This need was considered to be outside the remit of the GP.

Daithi: *"Yeah I went to counselling myself separately; I never used my GP for that."*

Researcher: *"Do you have counselling here?"*

Niamh: *"No, in the community drug team.... yeah I can talk to the doctor but I wouldn't go in and deep and talk to me doctor but I do find I can talk to me doctor, which is good ...but also the doctor doesn't have the time to sit and talk and listen..."*

There was a reluctance to access counselling within a treatment clinic as this required re-engaging with other drug misusers in this environment.

Tadhg: *"No, there's nothing here like you have to go down to see the... you'd have to go down to [clinic]...but that's where they go for the phy, all the worst of the worst go there you know that way?"*

This overall description of "getting sorted" describes the user's perception of what services are provided for them in general practice from their perspective. "Getting sorted" is often also applied to the process of obtaining heroin.

Limitations of the study

Given the aims and objectives of investigating care in general practice the sampling strategy provided confirmation that those interviewed were indeed currently in receipt of methadone treatment from a general practitioner rather than a treatment centre. Bias is possible and could not be fully controlled but it was considered to be a useful pragmatic approach. With the benefit of hindsight, limitations of this study could be that the use of the GP prescriber as gate keeper may have influenced the accounts of service users, however the fact that negative experiences with these GPs were elicited during the in-depth interviews, without probing, suggests that this approach was useful. The use of the GP as gate keeper to target these service users was a deliberate decision to ensure that vulnerable patients were protected and was also a method of ensuring that the participants would be able to provide rich material. Rich responses to the research question were produced and enabled an in-depth descriptive account to be generated.

Discussion

This study provides a novel insight into service users' views of the way treatment is delivered in general practice. The findings of this study point to service users' satisfaction that general practice is a different place from a treatment clinic and a location that provides a valuable service for them. The significance and social meaning of place in relation to the setting of general practice for methadone treatment has had little discussion in the literature prior to this work, although there has been emphasis in recent research on the features of micro environments in relation to safer injecting sites.³¹ There is now, in addition to this work, a growing recognition of the role that place and setting can play in shaping the health of individuals and populations.³²

The value placed on general practice in this regard in the study has resonance with the recent UK Essence study.³³ Using commissioned short pieces of 100 words from both GPs and patients, questions such as, 'What do you value from your GP?' identified similar concepts to this study, including being 'treated as an individual', 'valuing the GP's attention and time' and 'valuing the ability to consult well'. The reality of attending weekly in a confidential setting, (without drug-dealing taking place in the immediate vicinity), having designated appointment times "just like every other patient", having problems sorted out at this time and being afforded the opportunity to normalise their lives was described as distinctly related to the setting of general practice. A recent study has identified that service users who attend the National Drug Treatment Centre (NDTC) want dealing in the vicinity of their treatment site curbed.³⁴

All of the service users in the study spoke of valuing general practice for a variety of reasons. Many of the service users in this study (70%) were attending their general practice for five years or more. Experiences of these service users attested to a long-term personal doctor-patient relationship which is a feature of general practice, as in many cases "knowing the patient who has the disease has been identified as as important as knowing the disease that patient has."^{35,36,37} This 'knowability' of the treatment context and also the apparent change in status of the drug treatment client from what has been described as 'autonomous agent' to 'participant in treatment' is significant. This was not only defined by the unique nature of the doctor-patient relationship but also described by service users as a trust engendered by a familiarity with past care and where their doctor recognised their professional responsibility to their community in prescribing methadone. This highlights the importance of the GP's ability to consult well. Effective and intuitive consultation is at the heart of good practice and the ability to engage in a facilitative, rather than autocratic, manner has been advocated in many models of consultation.^{38,39,40}

Treating drug misusers with respect, listening to their concerns and those of their families has been actively desired and highlighted by drug misusers themselves as crucial to their treatment.⁴¹ However, three service users described their GP as a "phy doctor" (in terms of prescribing their methadone only) and expressed their disappointment with this type of consultation style. It would seem that the role of the methadone-prescribing doctor needs consideration, as there is potential to avoid full engagement, which could lead to missed opportunities to look after other

domains of health. The therapeutic commitment to working with patients addicted to drugs can be enhanced by education and support, as can reflective learning, teaching and training to improve the doctor patient relationship.^{42,43,44} International studies have suggested that a proactive and even interventionist approach to the consultation in relation to methadone dosing has been found to be important to service users. But this is an approach that needs greater resources as it requires that service providers or their support staff spend more time with patients.⁴⁵ The unique system of training Level 1 GPs historically encouraged a multidisciplinary team approach to care. Professionals such as pharmacists, psychologists, practice nurses and midwives attended the course together, albeit on an ad-hoc basis. However, since 2008 this training has been provided exclusively for GPs through an online learning format by the ICGP. This is in contrast to the UK, where the Royal College of General Practitioners (RCGP) advocates that treatment of drug misusers is multifaceted and normally requires a multidisciplinary response wherever possible. Training there is provided in collaboration with practice nurses, dispensing pharmacists, practitioners with a special interest and addiction specialists.⁴⁶

Two types of psychological services are currently provided in primary care, known as co-locational and autonomous models. Anecdotal evidence from GPs suggest that services involving psychological assessment at primary care level is their first choice for patients and for some patients, primary care is the only acceptable route into psychological services.⁴⁷

In this study the majority of service users reported being mainly satisfied with their treatment however service users have historically few expectations of care and these issues need further exploration.⁴⁸ Caution has to be expressed therefore as to what service users reasonably expect to receive from general practice in Ireland in the absence of any nationally negotiated service level agreements, drug service users' charters or national guidelines. To this end one of the recommendations of this study is that the training needs of practice staff be considered within a multidisciplinary focus in order to equip practitioners to provide a comprehensive approach to service users' needs in treatment.

The experiences described in theme one contribute to understanding current practice and identify areas for improvement in the treatment of drug misusers in general practice. The study in its totality suggests strategies which facilitate user involvement are central to the future success of methadone treatment protocols such as those that operate in Ireland. Future research is required to evaluate the importance of changing client needs and their expectations of what a methadone treatment protocol should deliver.

Author's contributions

The study was conducted by Linda Latham as part of a doctoral research programme affiliated to the University of Bath between September 2006 and September 2010.

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Ethical approval

Ethical approval was obtained from the ICGP Research Ethics Committee and the School for Health University of Bath, Research Ethics Panel.

Conflict of interest

Practising Registered Nurse Practitioner in Primary Care at one of the sites surveyed.

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APPENDIX 1

INTERVIEW TOPIC GUIDE

Thank you for agreeing to take part in this interview. As you know from the written consent that you signed, this interview is confidential, and your views will be treated anonymously.

TOPIC 1 GENERAL PRACTICE

- I'm interested in getting your views on what it's like attending here? (GP practice - for methadone maintenance)
- What are your views on general practice?
- Have you had a lot of dealings with GPs (before you started on methadone?)
- How much have you used GP services for your health care? (e.g. women's health, pregnancy? Men's health etc?)

TOPIC 2 METHADONE MAINTENANCE-(THE ROLE OF METHADONE AS A TREATMENT FOR DRUG ADDICTION)

- Do you think /feel you have a drug problem?
- How does it make you feel to be attending a GP for that problem /for methadone?
- Do you feel listened to? Are your views important?
- Do you feel that methadone has helped you? - What does it help you with?
- What more could be done to help?

TOPIC 3 PARTNERSHIP /INVOLVEMENT IN CARE

- If you are not happy with some aspect of how your treatment is going how able are you to voice your concerns?
- Have you ever had an experience that you negotiated a change in treatment? - can you tell me about that?
- What are your future plans?

TOPIC 4 PROTOCOL /INFLUENCING FACTORS

- What do you understand by the term methadone protocol?(Examples Urine testing/ take away doses/attending the GP every week)
- From your experience are there any aspects of this protocol that you would change?
- What do you feel influences GPs in taking on patients who are on methadone?

IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD?

- Thank you for taking part. If you wish I will give you back the transcript of your interview so you can check whether I have accurately reflected your views.