General Practitioner Engagement with the Scottish National Naloxone Programme:

A Needs Assessment Project

Report Appendices

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Appendix 1: Questionnaire

UNIVERSITY OF ABERDEEN

General Practice: Engagement with the Scottish National Naloxone Programme: A National Survey

For further information contact: Dr. Catriona Matheson, Academic Primary Care, University of Aberdeen.
T: 01224 437202; email: c.i.math@abdn.ac.uk

All answers will be treated as totally confidential within the research team.

CURRENT PRACTICE RELATING TO DRUG MISUSE

1. Do you currently treat drug misusers? ☐ Yes (go to 2) ☐ No (go to 4)
2. How many drug misusers (approx.) are seen for their treatment of dependency personally by you per month?
3. How many patients in the whole practice are on maintenance programme with methadone/buprenorphine or other opiate replacement?
4. Is your practice a dispensing practice? ☐ Yes ☐ No

DRUG RELATED DEATHS

5. Do you know approximately how many Drug Related Deaths there are in Scotland annually? (Tick **one** box only):

☐ <100 ☐ 100-250 ☐ 250-500 ☐ 500-750 ☐ >750 ☐ Don't know

6. Which of the following do you consider to be risk factors for Drug Related Deaths? (Tick **all** that apply):

☐ People who have been using illicit drugs for a long period of time
☐ People newly started on Opiate Replacement Therapy, e.g. methadone
☐ People who inject drugs
☐ People who take alcohol with other drugs
☐ People who take benzodiazepines with other drugs
☐ People who have recently (within past month) been released from prison
☐ People who are homeless
☐ People who have recently taken part in a detoxification programme
☐ People who have experienced additional psychological stress
☐ People who are under 24 years

7. Do you provide routine overdose prevention in your practice to persons at risk of opiate overdose?

☐ Yes ☐ No If Yes, who provides this _____

7a. How do you provide it:

_____

THE SCOTTISH NALOXONE PROGRAMME

Opioid overdose is a significant cause of death among drug users. Naloxone is an opiate antagonist commonly administered by emergency medical personnel for heroin overdose. The Scottish Naloxone Programme allows training and naloxone distribution to individuals at risk of overdose so that naloxone can be used before medical help arrives if a person suffers an opiod overdose.

8. Had you heard of the national programme of prescribing naloxone to persons at risk of opiate overdose prior to this survey? ☐ Yes ☐ No

If **Yes**, where from:

☐ Colleagues ☐ NHS communication ☐ other (please specify):

_____

9. Does your practice display or give out information on naloxone availability?

☐ Yes: we display a poster ☐ Yes: we distribute leaflets ☐ No

☐ Yes: other (please explain):

_____

10. Do you know who your naloxone lead is locally? ☐ Yes ☐ No

11. Have you had any involvement in the national programme to date?

☐ Yes ☐ No

If Yes, please explain: _____

12. Currently, would you know where to refer a drug user to access naloxone?

☐ Yes ☐ No

13. Would you be prepared to prescribe naloxone and explain its use to a patient at risk of opiate overdose?

☐ Yes ☐ No: please explain:

_____

☐ Unsure: please explain:

_____

14. Would you be prepared to prescribe naloxone and explain its use to family/friend of someone at risk of opiate overdose?

☐ Yes ☐ No: please explain:

_____

☐ Unsure: please explain:

_____

15. How important do you think the following factors are when considering how to extend the naloxone programme into general practice? (Please **tick one for each** option):

	Very Important	**Somewhat Important**	**Not Important**
GP themselves must receive appropriate training			
Practice nurses must receive appropriate training			
GP must be paid to provide this service in some way			
There must be evidence to support the naloxone programme			
It must be on the local formulary			
This service should be included in the Quality and Outcome Framework			

Delivering the naloxone programme in general practice could follow different models with different levels of input from GPs and other practice staff. The intervention can be broken down into two components: training in basic life support (BLS) and naloxone prescribing. Please indicate which of the features below you prefer?

Which model of delivery would you prefer (Tick which model you prefer)?

16. ☐ **Model One**: The whole intervention, i.e. training in basic life support and naloxone administration and naloxone supply. (**if ticked, go to 16a**)

Or

☐ **Model Two:** GPs will only prescribe and others will deliver BLS and naloxone training (**if ticked go to 16b**)

16a. If you prefer **model one**, who should provide this?

☐ GP ☐ Practice Nurse ☐ other: _____

16b. If you prefer **model two**, how should the intervention be delivered?
☐ One-to-one basis ☐ small groups ☐ No preference

17. What do you consider an appropriate length of intervention?

☐ 20 – 30 minutes ☐ A **brief intervention** ≤ 10 minutes
☐ other:_____

17a. If you prefer a **brief intervention**, should it be delivered opportunistically during routine appointments? ☐ Yes ☐ No

18. If naloxone has been used, who should debrief and resupply?

☐ GP ☐ Practice nurse ☐ Other: _____

19. Please indicate your attitudes to the following issues concerning naloxone distribution in general practice by ticking the appropriate boxes. (Tick **one for each** statement):

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
I believe General Practice based distribution of naloxone is essential to reduce drug related deaths.	☐	☐	☐	☐	☐
I am concerned that giving injecting drug users naloxone might encourage riskier injecting practices.	☐	☐	☐	☐	☐
I am worried that if naloxone is administered by a peer to an injecting drug user they might not phone for an ambulance.	☐	☐	☐	☐	☐
I believe the National Naloxone Programme is an important use of NHS resources.	☐	☐	☐	☐	☐
I feel confident in identifying and addressing overdose risks.	☐	☐	☐	☐	☐

TRAINING

20. Have you ever received specific training for treatment of drug dependency? ☐ Yes ☐ No

If yes, please tick **all** of the options that apply:

- RCGP training level 1 ☐
- RCGP training level 2 ☐
- Other credited postgraduate course ☐
- Local specialist service-run training course ☐
- Other (please specify) _____ ☐

21. Have you had any specific training on the prevention of Drug Related Deaths?

☐ Yes ☐ No

If No, would you be interested in drug related deaths prevention training? ☐ Yes ☐ No

22. How should Drug Related Deaths prevention training be delivered? (Tick **one** option only):

- ☐ Using Online resources
- ☐ National forum e.g. RCGP
- ☐ Locally delivered evening training
- ☐ Other: please specify:

_____

DEMOGRAPHIC DETAILS

23. Are you: ☐ Male ☐ Female
24. Years of experience as a GP: _____years
25. Is your practice site:

☐ City Centre ☐ Suburban ☐ Town (4,000-90,000 inhabitants) ☐ Rural(<4,000 inhabitants)

Finally, if you would be interested in piloting GP training as part of the naloxone programme please contact the naloxone programme lead: Stephen Malloy, email: stephenM@sdf.org.uk. T: 01412 211175

Thank you for taking the time to complete this questionnaire.

Appendix 2: Invitation Letter and Study Information Sheet

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Polwarth West Block
Aberdeen AB25 2ZD
Scotland
United Kingdom
Tel: +44 (0) 1224 437202
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Email: primarycare@abdn.ac.uk

Dear Dr.

Engagement with the Scottish National Naloxone Programme: National Survey of General Practitioners

Rates of Drug Related Deaths (DRDs) in Scotland are amongst the highest in Europe. One of the most important public health interventions being implemented to address this is the Scottish National Naloxone Programme which aims to increase the awareness and availability of naloxone to those who are at risk of opiate overdose. You should have received a letter from Dr Laurence Gruer recently explaining more about the study.

The engagement of General Practitioners (GPs) is essential to maximise the benefit of the programme. The UK Medicines and Health Care Regulatory Agency (MHRA) have recently agreed to licence the 'take-home' naloxone emergency kits created specifically for the national programme. This will effectively allow GPs to directly prescribe the 'take-home' kits.

Enclosed is a questionnaire that seeks your views on general practice involvement in the naloxone programme. We would really appreciate if you could complete this short questionnaire and return it to the study office in Aberdeen in the reply-paid envelope provided. The questionnaire has a unique number at the top. This is for the purpose of identifying responders for reminder purposes only. Please be assured that the data you provide is confidential to the research team.

- Completing this questionnaire should only take **10 minutes**, just long enough to enjoy a cup of coffee with our compliments!

We would greatly appreciate your input to help inform this important Scottish development. An information sheet is also enclosed with more background information.

Yours sincerely,

Catriona Matheson

Catriona Matheson (Principle Investigator)

Further Information

Naloxone is an opiate antidote which can temporarily reverse the effects of an opiate overdose; thus providing more time for an ambulance to arrive, treatment to be administered and possibly saving a life.

In 2005, the law in the UK was amended to permit emergency administration of naloxone by anyone. Since then, community addiction teams and harm reduction services have been training individuals in basic life support and naloxone administration, and supplying them with a 'take-home' naloxone kit. Typically, this involves nurses or pharmacists supplying naloxone immediately after training individuals at risk. This is done through the use of a Patient Group Direction (PGD). More recently, the Lord Advocate issued Local Guidelines which allows supply of naloxone to individuals working outwith the NHS who are in contact with individuals at risk of opiate overdose.

What is the purpose of the study?

The study will help to identify facilitators and barriers for General Practitioners to engage effectively with the naloxone programme in Scotland. Results will aid the development of appropriate supportive information and training materials.

Who has been invited to participate?

Questionnaires have been randomly sent to 10% of all General Practitioners in Scotland.

Who will co-ordinate the study?

This study is a collaboration between the University of Aberdeen and NHS Health Scotland. Principle Investigator is Dr. Catriona Matheson (telephone 01224 437202; email: c.i.math@abdn.ac.uk) who will be responsible for the day-to-day running of the project and is available to answer any queries that may arise.

Who has funded the study?

The study is funded by NHS Health Scotland and the Scottish Government Drugs Policy Unit.

Does the study have ethical approval?

Yes. This study has been approved by the University of Aberdeen, College Ethics Review Board.

What happens after the study is finished?

The findings of this study will be made available to all participating practices after completion of the research. Results will help to develop appropriate supportive information and enhance training materials.

Appendix 3: Topic Guide

General Practitioner Engagement with the Scottish National Naloxone Programme: A Needs Assessment Project: Interviews

- Explain purpose: The aim of these semi-structured interviews is to explore GPs views of providing a naloxone service and seek their views on how this might work in practice. This complements information being gathered in a quantitative questionnaire. Participants from this group will not be included in the quantitative sample.
- Each interview will last 20-30 minutes.
- Ask participant if willing to be tape recorded.
- Ask participant to complete the consent form by putting initials in the boxes and post back to the researcher.

TOPIC GUIDE

Experience

What is your current experience of working with substance misuse?

Have you ever prescribed naloxone?

Awareness

Have you heard of the Naloxone programme in Scotland?

(Before you received this, were you aware of the naloxone programme?)

Willingness

Would you be willing to participate in the naloxone programme?

Are you willing to train families/peers?

Would you be willing to prescribe naloxone?

Practical Delivery

How could this work in your practice?

Do you see this as a role for the GP/practice nurse/someone else?

Identifying needs/resources

What would you need to help you deliver this service?

Are there specific resources would you need if you participated in the programme?

If not willing to participate yourself, would you refer patients elsewhere?

Barriers (if not mentioned already)

Do you foresee any barriers to primary care delivery of naloxone?

Appendix 4: One Page Questionnaire

UNIVERSITY OF ABERDEEN

General Practice Engagement with the Scottish National Naloxone Programme: A National Survey

1. Do you currently treat drug misusers? ☐ Yes ☐ No
2. Had you heard of the national programme of prescribing naloxone to persons at risk of opiate overdose prior to this survey? ☐ Yes ☐ No
3. Would you be prepared to prescribe naloxone and explain its use to a patient at risk of opiate overdose? ☐ Yes ☐ No ☐ Unsure

4. How important do you think the following factors are when considering how to extend the naloxone programme into general practice? (Please **tick one** for each option):

	Very Important	**Somewhat Important**	**Not Important**
GP themselves must receive appropriate training			
Practice nurses must receive appropriate training			
GP must be paid to provide this service in some way			
There must be evidence to support the naloxone programme			
It must be on the local formulary			
This service should be included in the Quality and Outcome Framework			

5. How should Drug Related Deaths Prevention training be delivered? (Tick **one** option only):
- ☐ Using Online resources
- ☐ National forum e.g. RCGP
- ☐ Locally delivered evening training
- ☐ Other: please specify:

_____

6. Are you: ☐ Male ☐ Female
7. Is your practice site:
☐ City Centre ☐ Suburban ☐ Town (4,000-90,000 inhabitants) ☐ Rural (<4,000 inhabitants)

Thank you very much for completing this questionnaire.

Appendix 5: New Reminder Letter

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Polwarth West Block
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Scotland
United Kingdom
Tel: +44 (0) 1224 437202
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Dear Dr.

Final Reminder

Engagement with the Scottish National Naloxone Programme: National Survey of General Practitioners

We recently sent you a questionnaire to gain your views of how the naloxone programme can be implemented in primary care to reduce drug related deaths. To enable you to participate:

We have drastically shortened the questionnaire – it now takes less than 5 minutes to complete!

We appreciate there are many demands on your time so we have reviewed the questions and include only those most important to inform how naloxone prescribing can be implemented by all general practitioners.

This questionnaire is aimed at all GPs not just those with specialist involvement with drug misusers.
We want to ensure fair representation of Scottish GPs views so that we can make evidence based recommendations to NHS Health Scotland and the Government Drug Policy Unit.

The questionnaire is anonymous, there is no identifier on it.
Please complete the questionnaire and return it in the reply-paid envelope by the 2nd November for your views to be included. An information sheet is enclosed if required.

Thank you in anticipation.

Yours sincerely,

Catriona Matheson

Catriona Matheson (Principle Investigator)

Further Information

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Appendix 6: Comparisons of Long and Short Questionnaires for common questions

Q24		Long n=	Short n=55	All n=237	
	Male %:	48.9%	34.5%	45.6%	p=0.086

Q26		City	Suburban:	Town:	Rural:	
	Long n=179	39 (21.8%)	30 (16.8%)	79 (44.1%)	31 (17.3%)	p=0.845
	Short n=57	15 (26.3%)	9 (15.8%)	22 (38.6%)	11 (19.3%)	
	All n=236	54 (22.9%)	39 (16.5%)	101 (42.8%)	42 (17.8%)	

Q1	Currently treat:	Long: n=183	Short: n=56	All: n= 239	p=**1.000**
		87 (47.5%)	26 (46.4%)	**113** (47.3%)	

Q8	Heard of the national program?:	Long(183)	Short (57)	All(240)	p=0**.064**
		111 (60.7%)	26 (45.6%)	**137 (57.1)**	

Q13			Yes:	No:	Unsure:	
	Prepared to prescribe & explain naloxone to patients at risk?	**Long (181)**	88 (48.6%)	40 (22.1%)	53 (29.3%)	
		Short (57)	16 (28.6%)	13 (23.2%)	27 (48.2%)	p=0.014
		All n=237	104(43.9%)	53 (22.4%)	80 (33.8%)	

Q15			Very Important	Somewhat Important	Not Important	n	Set p<0.008??
	GP appropriate training	Long	143 (80.3%)	28 (15.7%)	7 (3.9%)	178	
		Short	50 (90.9%)	5 (9.1%)	0	55	p=0.133
		All	193 (82.8%)	33 (14.2%)	7 (3.0%)	233	
	Practice Nurses appropriate training	Long	87 (52.1%)	49 (29.3%)	31 (18.6%)	167	
		Short,	29 (52.7%)	19 (34.5%)	7 (12.7%)	55	p=0.551
		All	116 (52.3%)	68 (30.6%)	38 (17.1%)	222	
	GP paid for service	Long	70 (39.5%)	76 (42.9%)	31 (17.5%)	177	
		Short	31 (56.4%)	16 (29.1%)	8 (14.5%)	55	p=0.083
		All	101 (43.5%)	92 (39.7%)	39 (16.8%)	232	
	Have supporting Evidence	Long	156 (88.1%)	19 (10.7%)	2 (1.1%)	177	
		Short, FET	52 (94.5%)	3 (5.5%)	0	55	p=0.461
		All	208 (89.7%)	22 (9.5%)	2 (0.9%)	232	
	Must be on local formulary	Long	118 (66.7%)	48 (27.1%)	11 (6.2%)	177	
		Short,	38 (69.1%)	9 (16.4%)	8 (14.5%)	55	p=0.062
		All	156 (67.2%)	57 (24.6%)	19 (8.2%)	232	
	Should be included in the QOF	Long	20 (9.8%)	45 (26.3%)	106(62.0%)	171	
		Short	13 (24.1%)	19 (35.2%)	22 (40.7%)	54	**p=0.013**
		All	33 (14.7%)	64 (28.4%)	128 (56.9%)	225	

Q23	Training	Long n=159	Short n=42	All n= 201	
	Using Online resources:	54 (34.0%)	11 (26.2%)	65 (32.3%)	p=0.257
	National forum e.g. RCGP:	3 (1.9%)	3 (7.1%)	6 (3.0%)	
	Locally delivered evening training:	71 (44.7%)	21 (50.0%)	92 (45.8%)	
	Other:	31 (19.5%)	7 (16.7%)	38 (18.9%)	

Appendix 7: Qualitative Tables for Question 13 & Question 14

Q13a (Verbatim for 'No' would not prescribe to a patient)	Q14a (Verbatim for 'No' would not prescribe to a patient's family/friend)
No interest	We have enough problems with addicts occupying huge amounts of our time with inappropriate use of 'Emergency appointments & DNAS
No Experience	As 13a
Nurse specialist does this	As 13a
Feel this should be part of secondary care drug service	No training in giving such advice
We do not participate in Addictions Enhanced Service	
I would find need to feel that I could provide this service as well as other local training	
Refer to lead GP	Refer to lead GP
Not trained	Not trained
How can they give it to themselves if they O.D.? Short acting-how do they repeat it?	1. Difficulty owing I.V 2. Freq of dosage 3. How to repeat prescribe if out of date
No training	No training
Lack of experience	As 13a
Practice has made decision not to. Very small number of pts using drugs in our area. More important to do other training.	Practice has made decision not to. As 13
Should be monitored by addictions team	Feel this should be done by addiction team
Good facility already in place	As 13a
	Best done by specialist services
? Quantity? method etc. risk of seizures	
Time constraints that would prevent doing this properly	As 13a
It should be part of a drug treatment programme	As 13a
I have no experience of this & have the same service via methadone clinic	As 13a

Q13a (Verbatim for 'No' would not prescribe to a patient)	Q14a (Verbatim for 'No' would not prescribe to a patient's family/friend)
I don't see drug addicts	
Done by harm reduction already	As 13a
	Time implications but would be happy to refer
All patients are seen by LAAD's	As 13a
Not trustworthy	
Expect those involved who know more to do it though happy to advise where to get it.	Currently we are not engaged in drug addiction and it is less confusing if addicts attend a place with experience
Lack of training, very few drug users in our practice	As 13a
	Don't know what to say/do/prescribe
We are not part of health board methadone LES. We do prescribe for 2 addicts who we've known for 20+ years	As 13a
The provision of a weapon to drug dealers (for poor people) is irresponsible	
Better advice from the locality clinic	Better to come from the specialist clinic
	Confidentiality issue
Specialist	Specialist
Concern may allow some to increase drug dose as now have "safety net"	As 13a
I feel I would like to have some training first to make sure I was explaining the correct way to use it & give basic l	Again I'd feel happier to have some training on what we should be telling patients/family, especially if they have no
No time/over capacity	No time
More what to say/how much to give	As 13a
There is a dedicated service	As 13a
Unskilled	As 13a
YES: In our locality this is currently handled by Signpost/CADS	
	Unsure: the addiction team do this

Q13b (Verbatim for 'Unsure' about prescribing to a patient)	Q14b (Verbatim for 'Unsure' about prescribing to a patient's family/friend)
	I would be more likely to take them to a professional person to have it explained
	Most of our patients with drug related problems are currently followed up by community addiction service
I haven't had any experience of its use except in hospital environment so would need to talk to someone more experiment	As 13b
Time restrictions/reluctance of these patients to attend surgery or when appt. given as we do not prescribe methadone	
Would prefer this service to be provided by local addictions team	Would prefer this service to be provided by local addictions team
Concerned about prescribing antidote to illegal substance and one where discordance effects are minimized	As 13b
Don't know enough about it/don't know what local protocol is	
Never had experience doing such	
	Issue of patient consent ie the person to whom the naloxone would be administered
All drug/opiate prescribing done elsewhere in our locality + would probably confuse LES	As above 'confusion' of prescribing responsibility
	Potentially with clear guidance
Part of management of drug users so should be handled by them + I am not appropriately trained	
Yes with funding for packs & education & administration	
Need Training	Need Training
Unsure what is involved	Unsure what is involved
Think that practical demonstration would be required, don't have equipment or time resource to do this properly	As 13b
Need more information + training in use	Need more information + training
Time pressures on consultation could be an issue	Time pressures as above. -10 minute consultations are limited by nature. -this sounds really useful but difficult to a
Never prescribed before, would prefer some guidance/training	Invalid response
TIME. Already SMS patients are very time-intensive, Best focus effort on more chaotic patients seen by SMS CPNs	As 13b
Q13b (Verbatim for 'Unsure' about prescribing to a patient)	**Q14b (Verbatim for 'Unsure' about prescribing to a patient's family/friend)**
I need more info	I need more info

If had adequate literature/advice storing	Again if appropriate training, protocol adhered to & accepted practice in responsible individual
Do not undertake drug misuse management at this practice	
Would need to know more about it	
Deskilled in this area all drug maintenance done out with practice	As 13b
Need training in this	As 13b
If appropriate patient(currently not treating anyone)	
	Difficulty of talking to family/friends- may not attend/be contactable/patient may not give consent
This is usually done by our addiction nurse	As 13b
Probably yes with a little more training/information	As 13b
My own lack of knowledge & experience	As 13b
I would feel more comfortable if they had training elsewhere	As 13b
	Possibly
Would need some education myself + prefer to do in conjunction with SM team	As 13b
I would need to refresh my knowledge before explaining this to a patient	In the emergency situation I would do this. If it was routine I would advise they see their own GP for this
Time implications, info given by CPNA	
We do not treat drug users frequently	As 13b
Dependent on guidelines + local policy	As 13b
Don't treat drug users, centralized in secondary care clinic	
I have not seen or used the kits	Would require training or at least familiarising with kit
Happy to prescribe, prefer info to come from elsewhere	
Would refer to local Drug Team	
Q13b (Verbatim for 'Unsure' about prescribing to a patient)	**Q14b (Verbatim for 'Unsure' about prescribing to a patient's family/friend)**
Would need more training on who to offer to etc.	As 13b
Depending on practice agreed policy & advice on how to do	As 13b

I would wish to but time restrictions would make it difficult to incorporate	As 13b
	Confidentiality could be an issue
With appropriate training I would RX	With appropriate training I would RX
Would need more info - suitable patients safety consideration	More info first - suitability criteria etc
Need training	As 13b
Since we do not deal with illicit drug substitutes we would normally prefer to refer on to appropriate local services	As 13b
Don't know enough about risk/benefit research	As 13b
I would need more training. Methadone prescriptions are managed by 2 senior male GP's in the practice. It would be more	I would need more training. Methadone prescriptions are managed by 2 senior male GP's in the practice. It would be more
Never done it, not really sure what needed	Don't feel I know enough/have experience to do so.
Need more information	Need more information
As long as their care was being coordinated throughout local addictions service	As 13b
	I have not come across anyone with opiate overdose, I feel that gradual escalation of opiod use/misuse leads to a bit of tolerance, I have not encountered this as a clinical problem.
Think should probably be done by substance misuse prescribing team	As 13b
I'd rather explain that it is better not to be at risk	I'd be prepared to discuss
No experience	No experience
	Huge responsibility for that person - in most cases I would prefer the drug user to take the responsibility
Need to discuss with other partners what the practice policy will be	As 13b

Qualitative comments for those answering NO or UNSURE to Q13,Q1