General practitioners’ views on drug-assisted rehabilitation

Summary

Background. The Norwegian model for opioid maintenance treatment (OMT) «Drug-assisted rehabilitation» (DAR) is a cross-disciplinary tripartite model for the treatment of opioid dependence. The model requires collaboration among GPs, the social services and the specialist health services. To some degree it restricts the doctor’s professional autonomy. The investigation aims to examine GPs’ attitudes to the model and in particular the experiences of those who have actively participated.

Material and method. An electronic questionnaire (Questback) was sent to Norwegian GPs listed on the members’ register of the Norwegian Medical Association. The respondents were questioned about their general opinions of drug-assisted rehabilitation. Those who had had relevant patients were asked about their experiences and evaluations based on 22 statements.

Results. 1,165 doctors (34 % of all registered GPs) responded to the survey. 155 (13 %) were negative, 395 (34 %) neutral, and 604 (53 %) were positive towards drug-assisted rehabilitation. 683 (59 %) were doctors with DAR experience. These were treating approximately 50 % of the country’s DAR patients. The tripartite model received significant support. Very few want greater autonomy. The majority also support the strong emphasis on monitoring, although some, particularly older doctors with DAR experience, believe that urine tests could be replaced by personal contact.

Interpretation. Drug-assisted rehabilitation was mainly viewed positively by Norwegian GPs in this sample. There was little opposition to the doctor’s role in the model, even though it restricts the autonomy of the individual doctor to some degree.

Substitution treatment with methadone or buprenorphine is currently the most common treatment for heroin dependence. The treatment was established in Norway as drug-assisted rehabilitation (DAR) in 1997. The model has been evaluated a number of times (2–5). The Directorate of Health issued guidelines based on special regulations in 2010 (6), but the basic model is unchanged. Evaluation of indication, choice of drug type and setting of the optimal dosage are to be carried out by the specialist health service. The GPs have a central part to play in the treatment, but cannot initiate it independently. It presupposes cooperation with the municipal social services and the treatment should build on the use of patient care groups and interventions. This therefore entails certain requirements in terms of GPs’ participation and a certain restriction on their free choice of treatment.

Pharmaceutical maintenance treatment with methadone was developed in the US, with strict monitoring requirements and emphasis on specialised centres. Today the design of the treatment model varies internationally. The Norwegian model has a model for shared care involving cooperation between specialist interventions and GPs.

The introduction of the regular GP scheme in 2001 and amendments to the Municipal Health Services Act and the Specialist Health Services Act in 2002 as well as the drugs policy reforms of 2004 have given doctors a more important role in the treatment of drug and alcohol dependence. Norwegian doctors’ views on these changes and on drug-assisted rehabilitation were investigated using questionnaire surveys of a panel of doctors in 2000 and 2006 (7). The majority were positive about the reforms, and moreover 53 % had a positive view of substitution treatment, both in 2000 and 2006. In 2000, 45 % were negative about prescribing methadone/buprenorphine themselves, while this proportion was 33 % in 2006.

In January 2010, 3,583 patients were in drug-assisted rehabilitation. 3,500 (66 %) of these were being treated by GPs cooperating with DAR teams (8). One year later, 6,015 patients were in DAR treatment. 4,090 (68 %) of these received the DAR drug prescribed by their GP (9). A significant number of Norwegian doctors are therefore participating in a tripartite collaboration with the social services (the Norwegian Labour and Welfare Service – NAV) and the specialist health service. Some doctors have been very critical of drug-assisted rehabilitation (10). Others believe that GPs possess the competence to have greater responsibility within the model (11). There has been

Main message

■ Drug-assisted rehabilitation of heroin dependents is a model that requires cross-disciplinary collaboration according to established guidelines

■ The model is supported by the majority of the GPs in this study.

■ Older, experienced doctors were somewhat more positive towards a relaxation of control routines

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severe criticism from a criminological and legal angle of an authoritarian «methadone inspectorate» (12).

Drug-assisted rehabilitation today has become an integrated part of the health services, the experience base is broader and the debate is more refined. In this study we wished to investigate whether the changes have altered Norwegian GPs’ views of this form of treatment and how doctors with DAR experience evaluate the Norwegian model of shared responsibility and tripartite collaboration. This is important both for the further development of drug-assisted rehabilitation and for discussions on collaborative models for multidisciplinary health services.

Material and method

A sample of 3 770 GPs was drawn from the members’ register of the Norwegian Medical Association in November 2009. These encompassed all GP’s in the register at the time, minus a random sample of 500 who were used in another study. These doctors received an e-mail in June 2010 with a link to an electronic questionnaire (QuestBack) and information that the Norwegian Centre for Addiction Research at the University of Oslo (SEARF), the reference group for addiction medicine of the Norwegian Association of General Medicine (Norwegian Medical Association) and the Research Institute of the Norwegian Social Science Data Services.

The questionnaire was in two parts. The first part contained questions about attitude to and opinions on drug-assisted rehabilitation. Those who had participated in this type of treatment completed Part 2 with 22 statements about the model, formulated on the basis of the debate in professional forums. The general evaluations were surveyed using a three-point value scale (negative-neutral-positive) and the specific opinions using a five-point Lickert scale from 1 (strongly disagree) to 5 (strongly agree). The survey was anonymous, but we asked about gender, age, list size, county and specialisation in general medicine as well as the number of DAR patients over all and at the time of responding. The results are primarily presented in descriptive form. We use percentages and average values to describe tendencies and group comparisons and logistic regression to describe concurrent effects. The four dependent variables in the regression analyses were all on an ordinal scale from 1–5. The odds ratio represents the change in the association that takes place by moving one ordinal place on the scale, e.g. from 1 to 2. An odds ratio higher than 1.0 thereby indicates a significant association between the independent variable and greater support for the attitude statement in the model. Statistical significance is tested using the chi-squared or 95% confidence interval. All the analyses were conducted using Predictive Analytics SoftWare Statistics (PASW), version 18.

Results

Of the 3 770 GPs invited, 243 used the unsubscribe link. 120 questionnaires were returned due to invalid e-mail addresses. The real percentage of responses was 34 (1 165/3 407). Of these, 411 (35%) were women and 750 (65%) were men (non-respondent = 4). The respondents had worked an average of 16.2 years as GPs. The majority were specialists or in specialist training in general medicine. The average number of patients on their lists was 1 191.

883 doctors (76%) had experience of systematic treatment and follow-up of patients with substance abuse problems generally. 321 (28%) had not referred a patient for specialist substance abuse treatment in the past year, while 766 (66%) had done this «a few times». Only 72 (6%) had made referrals monthly or more frequently. 683 (59%) of the respondents had at some time participated in DAR treatment. These are referred to as DAR doctors in this article. 149 (22%) of the DAR doctors had no DAR patients at the time of responding. The remaining 534 (78%) had a total of 2 028 DAR patients. At the time of the survey this represented approximately 53% of all DAR patients being treated by GPs, calculated as the median of the number at the beginning and end of the year. 445 (65%) of DAR doctors had fewer than six DAR patients, 215 had six to ten DAR patients and 23 doctors had more than ten DAR patients. Five doctors had more than 20 DAR patients, whereas three had 30 or more. One doctor had 70 patients and one

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Representativeness of the sample in terms of gender, age, region and specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>ouro respondents</td>
<td>All GPs in November 2009</td>
</tr>
<tr>
<td>Number</td>
<td>1 165</td>
</tr>
<tr>
<td>Proportion of women, percentage [95% CI]</td>
<td>35.4 (32.6–38.0)</td>
</tr>
<tr>
<td>Age, percentage [95% CI]</td>
<td></td>
</tr>
<tr>
<td>≤ 40 years</td>
<td>31.4 (28.5–33.9)</td>
</tr>
<tr>
<td>41–55 years</td>
<td>39.0 (36.1–41.7)</td>
</tr>
<tr>
<td>&gt; 55 years</td>
<td>29.6 (26.9–32.1)</td>
</tr>
<tr>
<td>County, percentage [95% CI]</td>
<td></td>
</tr>
<tr>
<td>Østfold, Akerhus, Oslo, Hedmark, Oppland</td>
<td>35.1 (30.5–39.4)</td>
</tr>
<tr>
<td>Buskerud, Vestfold, Telemark, Aust- and Vest-Agder</td>
<td>9.1 (5.3–12.9)</td>
</tr>
<tr>
<td>Rogaland, Hordaland, Sogn og Fjordane</td>
<td>21.8 (16.7–26.9)</td>
</tr>
<tr>
<td>Møre og Romsdal, Sør-Trøndelag, Nord-Trøndelag</td>
<td>13.4 (8.0–18.8)</td>
</tr>
<tr>
<td>Nordland, Troms, Finnmark</td>
<td>10.8 (5.4–16.2)</td>
</tr>
<tr>
<td>Specialist in general medicine, percentage [95% CI]</td>
<td></td>
</tr>
<tr>
<td>Non-specialist</td>
<td>5.9 (4.3–6.9)</td>
</tr>
<tr>
<td>In specialist training</td>
<td>27.9 (25.2–30.4)</td>
</tr>
<tr>
<td>Specialist</td>
<td>65.1 (63.1–68.5)</td>
</tr>
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<table>
<thead>
<tr>
<th>Opinion</th>
<th>Strongly disagree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with addictions often have multiple problems that is useful to work on with a cross-disciplinary team</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>It is reassuring not to have sole responsibility for DAR patients</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>The social services are an important partner</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>It is easier to work out an individual plan in patient care groups</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Patient care groups provide a basis for good collaboration with the social services</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>The tripartite model provides a good basis for continuity and a comprehensive approach in treatment</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Patients with addictions should be treated just like other patients in the specialist health service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAR is mainly about harm reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings are often badly managed</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>The DAR Centre/the specialist health service are of little help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of my DAR patients need benzodiazepines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The patient care groups take up too much time</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>With some of my DAR patients, the urine tests should be replaced by counselling and personal evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I lose income by participating in DAR</td>
<td></td>
<td></td>
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<tr>
<td>There is a requirement of collaboration that can weaken the GP’s autonomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We as doctors should be able to decide indication and treatment ourselves</td>
<td></td>
<td></td>
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<tr>
<td>Doctors who participate in DAR treatment are being treated as though not fully qualified</td>
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<tr>
<td>There is too much monitoring of patients in DAR</td>
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<td></td>
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<tr>
<td>Some of my patients would benefit more from morphine sulphate, e.g. Dolcontin</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>The DAR team is a hindrance in my work with DAR patients</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Some of my DAR patients should be able to have heroin dispensed to them at a treatment centre</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>I would rather have sole responsibility for overall treatment and consult with the social services as necessary</td>
<td>*</td>
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</tbody>
</table>

**Figure 1** Opinions on DAR measured by median distribution of responses on a line between 1 = strongly disagree and 5 = strongly agree. The median is marked by a thick vertical line. The boxes – the horizontal rectangles – show the percentile from 25% to 75%. The thin lines indicate responses above and below these percentiles. Single random variable responses are marked with an asterisk. The questions are ranged according to decreasing median values and therefore according to degree of agreement/disagreement.
Attitudes to DAR

The attitudes to substitution treatment (DAR) varied: 155 (13%) were negative, 395 (34%) were neutral, while 607 (53%) described a positive attitude. 414 (36%) «would not think of prescribing methadone or buprenorphine themselves». 572 (49%) were positive towards participating in such treatment, while 172 (15%) were unsure.

Experiences as a DAR doctor

The group with experience as DAR doctors were asked what it was like to be a doctor for DAR patients. 252 (37%) responded that it was positive, 261 (38%) were neutral, while 167 (25%) considered it negative. The DAR doctors’ scores for the specific statements in Part 2 are presented in Figure 1. The majority value collaboration in this field, and the tripartite model has strong support in this sample. Few want sole responsibility for treatment and very few consider the specialist health services to be a hindrance. The doctors in the sample for the most part support the monitoring of treatment and the restrictions on doctors’ autonomy. Few DAR doctors find that the patient care groups take up too much time or are often badly managed. The statement that drug-assisted rehabilitation is mainly about harm reduction divides the respondents into two groups with the emphasis on «partly agree» and «partly disagree». The same applies to the question of whether doctors find the specialist health services helpful.

Table 2 shows the effect of list size, specialist status, health region, age and gender on four different DAR-related factors. The value placed on participation in drug-assisted rehabilitation is generally independent of gender, list size, experience of substance abuse treatment and specialist status. Younger doctors tend to have a more negative attitude to the model, whereas those who have had many DAR patients are more positive. The collaboration with the specialist health services is considered to be more positive in Central Norway and in the counties that previously comprised Health Region South. Those with many DAR patients and those working in North and Central Norway disagree to a greater extent that drug-assisted rehabilitation is mainly about harm reduction. There is somewhat greater support for the statement that some DAR patients need benzodiazepines among those who have had many DAR patients and those working in North Norway. An increasing number of DAR patients on a doctor’s list is associated with increased satisfaction with being a DAR doctor and greater open-mindedness about prescribing benzodiazepines, but less agreement that drug-assisted rehabilitation is mainly about harm reduction.

Discussion

A majority of this sample of Norwegian GPs accept the DAR model, as the surveys of
regions. It is regarded most positively in South and Central Norway, where there is more active collaboration between GPs and the specialist health services (8, 9). This can be viewed as supporting the development of drug-assisted rehabilitation as a collaboration between GPs and a specialist health service with responsibility for follow-up. Similar experiences have been described in Scotland, Australia (18) the US (13, 19) and Canada (20). Also, experience from Ireland, for example, shows that GPs who provide substitution treatment without specialist support may have moderate results (21). However, French experience of GPs issuing prescriptions without any training requirements or any particular guidelines is judged as positive, although the evaluation is mostly not based on systematic surveys. All in all, knowledge of GPs’ experience is somewhat limited. This Norwegian survey is therefore an important contribution.

Despite four reminders, survey participation was relatively low. This is a common experience with questionnaire surveys sent to doctors (22), in particular to GPs (22, 23). A number of international studies have lower participation (24–26). Selection bias cannot be ruled out, but the findings are supported by previous representative panels of Norwegian GPs (7). Moreover, the selection is representative of Norwegian GPs in terms of gender, age and list size. Furthermore, the findings correspond to a 2002 survey conducted by the Norwegian General Practitioners’ Association (27).

There is an over-representation of DAR doctors in the study. This is regarded as favourable, in that the main purpose is to investigate the experience that doctors have of participating in DAR treatment. It is worth noting that the DAR doctors who responded to the survey have treated over half of all DAR patients to whom prescriptions have been issued by GPs. The responses therefore represent a majority of DAR-active doctors. It is possible that doctors with negative experiences of drug-assisted rehabilitation have not wished to participate. However, it is judged to be equally probable that doctors with clear opinions, both positive and negative, are more easily motivated to participate, while doctors with less interest and no clear standpoint may have failed to respond. Moreover, the DAR doctors are representative of the doctors who participated, and the latter in their turn are representative of Norway’s GPs in terms of age, gender and list size, and do not distinguish themselves particularly when it comes to workload and geographical affiliation.

The conclusion is that the DAR model is well adapted to the health-care situation in Norway. There was little opposition to the use of a collaborative model although this does to some extent restrict the autonomy of the individual GP.
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References


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