GP prescribing of opioids to opiate-dependent patients
Secondary analyses of data collected during a national survey of general practitioners in England and Wales in mid-2001

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The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals’ well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:
- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

Reader information

- **Document purpose**: This study aims to interpret the headline findings from a survey of substitute opioid prescribing to opiate misusers by GPs across England and Wales (Strang et al., 2005), and to identify their current relevance.

- **Title**: GP Prescribing of Opioids to Opiate-Dependent Patients: Secondary Analyses of Data Collected During a National Survey of General Practitioners in England and Wales in mid-2001

- **Lead author**: John Strang

- **Publication date**: April 2007

- **Target audience**: Primarily providers and commissioners of drug treatment services in England.

- **Circulation list**: Managers and commissioners of treatment services, co-ordinators and chairs of local partnerships (e.g. drug action teams and crime and disorder reduction partnerships), service user and carer groups, commissioners of pharmaceutical enhanced services local pharmaceutical committees, regional government department leads on drugs, central government department leads on drugs.

- **Description**: A further analysis of data from a survey of English GPs to explore more fully various aspects of the original findings. The areas under investigation include regional variation, urban versus rural practices, age and gender associations of the prescribing doctor, and variations across different forms of methadone, buprenorphine and dihydrocodeine.

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- **Gateway/ROCR approval**: The NTA is a self-regulating agency in relation to the Department of Health Gateway

Disclaimer

This publication is not a journal publication and does not constitute National Treatment Agency or Department of Health guidance or recommendations. The views expressed by this study are not necessarily those of the Department of Health or the NTA, but are based on externally refereed research.
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1 Background

In mid-2001, when the NTA was being established, data was collected nationally for the first time on substitute opioid prescribing to opiate misusers by GPs across England and Wales. This data has been analysed at a basic level, and a paper on these findings (Strang et al., 2005) has been published in the British Journal of General Practice. This 2001 survey identified the substantial extent of GP involvement in treating opiate misusers, but also identified apparently serious deficiencies in the nature of much of this GP prescribing – especially around the widespread use of methadone doses well below doses now recommended by NTA and others, and also the frequent provision of weekly take-home dose instalments.

2 Summary of the British Journal of General Practice paper

- Patients addicted to opiates had been seen by 51 per cent of GPs in the preceding four weeks (mean of four such patients), of whom 50 per cent had prescribed substitute drugs – thus providing a study sample of 1,482 opiate misusers to whom GPs were prescribing
- The drugs prescribed were methadone (86.7 per cent), dihydrocodeine (8.5 per cent) or buprenorphine (4.4 per cent)
- The majority of these substitute prescriptions were for the drug in oral liquid form (83.4 per cent); 15.3 per cent for the drug in tablet form and 1.3 per cent for the drug in the form of injectable ampoules. However, this distribution was not maintained across the different substances prescribed. For example, only 37 of the 225 prescriptions for tablets were for methadone, while all 19 of the prescriptions for opioids in ampoule form were for methadone ampoules
- Two-thirds (64.6 per cent) of these opioid prescriptions had been issued in the context of a local shared care arrangement. However, while it was common for both methadone and buprenorphine prescribing to be within shared care (68.6 and 62.5 per cent respectively), this was not the case with dihydrocodeine prescribing, of which only 26.7 per cent was within shared care arrangements
- Doses prescribed were surprisingly low-dose. Of 1,292 methadone prescriptions, the mean daily dose was 36.9mg – 47.9 per cent being for 30mg or less
- Weekly take-home doses were frequently authorised. Of these prescriptions, 44.6 per cent stipulated dispensing at daily intervals, while 42.9 per cent permitted weekly take-home supply.

1 We are unable to determine whether the prescribed daily dose also includes detox dosing since this distinction was not made in the questionnaire.

3 Methods

3.1 Development of a questionnaire

A questionnaire was developed utilising some items from the 1985 Glanz et al. questionnaire and expanding on selected areas. The domains covered by the questionnaire included the GPs’ demographics, their current involvement in treatment provision, attitudes and beliefs about managing drug misuse, appropriateness of, and confidence in their ability to provide a range of services and availability of local support, extent of contact with opiate misusers in the previous four weeks and prescription details – patient prescription data was also obtained on opiate addict patients treated during preceding four weeks (details of drug prescribed, form, dose, dispensing arrangements, whether NHS or private and shared care arrangements). The questionnaire employed is reproduced in the Appendix.

3.2 Sample

In mid-2001, a ten per cent random sample (3,023) of the 30,000 GPs across England and Wales was sent self-completion postal questionnaires. Following four mailshots, a 66 per cent (1,999 out of 3,023) response rate was achieved. Data was collected on both GP management and treatment of opiate misusers using the questionnaire detailed above.

4 Rationale for secondary analyses

It was proposed that additional analyses should be undertaken to explore more fully various aspects of these findings, such as regional variation, urban versus rural practices, age and gender associations of the prescribing doctor, and variations across different forms of methadone and buprenorphine and dihydrocodeine. These would enable better interpretations of the disturbing headline findings from the survey (published in the British Journal of General Practice and summarised in section two), and also to identify their current relevance.

5 Results of secondary analyses

To be of use to the National Treatment Agency, the secondary analyses only include data pertaining to the GPs responding to the 2001 survey who were from England (GPs from Wales were excluded). However, it should be noted that some of the data and analyses presented here have been mentioned in the British Journal of General Practice paper but relate to the entire sample (English and Welsh GPs), whereas in this report they relate to just the English GPs.

Of the 1,999 respondents to the 2001 national survey of GPs, 1,879 (94 per cent) were from England. Half of the English GPs...
GP prescribing of opioids to opiate-dependent patients in 2001: Secondary analyses of data collected during a national survey of general practitioners in England and Wales in mid-2001

(50.5 per cent; 948/1877) had seen at least one opiate misuser in the previous four weeks, of whom 50.5 per cent (478/946) had prescribed substitute opioids in at least one case. GPs were also asked to provide data on the substitute opioids they had prescribed in the previous four weeks. Three hundred and ninety-five GPs provided details on the prescriptions. Table 1 summarises the data collected.

Table 1: Summary of data collected from English GPs

<table>
<thead>
<tr>
<th>Variable</th>
<th>% (n)</th>
<th>mean</th>
<th>range</th>
<th>valid (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>66.2% (1241/1875)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>33.8% (634/1875)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td>44.75</td>
<td>27–69</td>
<td>(1297)</td>
</tr>
<tr>
<td>Years qualified as a doctor</td>
<td>20.71</td>
<td>1–45</td>
<td>(1858)</td>
<td></td>
</tr>
<tr>
<td>Years qualified as a GP</td>
<td>14.37</td>
<td>0.08–43</td>
<td>(1847)</td>
<td></td>
</tr>
<tr>
<td>Works full-time or part-time</td>
<td></td>
<td>Full-time 76.6% (1345/1712)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part-time 21.4% (367/1712)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. hours worked in a typical week</td>
<td>42.94</td>
<td>6–168</td>
<td>(1400)</td>
<td></td>
</tr>
<tr>
<td>No. full-time equivalent GPs</td>
<td>4.28</td>
<td>1–15</td>
<td>(1862)</td>
<td></td>
</tr>
<tr>
<td>Location of practice</td>
<td></td>
<td>Urban 49.2% (791/1609)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suburban 32.6% (524/1609)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural 18.3% (294/1609)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Summary of English GP demographic information

The structure of this report

The secondary analyses are split into seven sections:

1. Section seven reports on data relating to all English GPs who responded to the 2001 survey
2. Section eight reports on data from the GPs who had seen an opiate misuser in the previous four weeks
3. Section nine reports on data from GPs who prescribed substitute opioids to at least one of the opiate misusers they had attended in the previous four weeks
4. Section ten reports on composite scores in relation to remuneration, whether GP saw an opiate misuser, whether GP prescribed and whether the prescribing was in shared care
5. Section 11 provides a regional breakdown of drugs prescribed
6. Section 12 details prescribing and dosing
7. Section 13 provides an overview and some preliminary conclusions.

Data from English GPs

7.1 Who were the GPs in the sample?

Two-thirds of GPs in the sample were male. GPs in the sample had a mean age of 45, had been qualified for nearly 21 years and had worked as GPs for just over 14 years. Over three-quarters of the sample worked full-time and the mean number of hours worked per week was approximately 43. The average number of full-time equivalents at the practice was four and almost 50 per cent of the sample described their practice location as urban. Table 2 summarises the GP demographic information. Statistics collected for 2001 by the Department of Health relating to all
English GPs show our random sample to be demographically representative; nationally 64 per cent of GPs were male, the median age fell in to the 45-49 age band (DH, 2001) and 19 per cent were working part time (DH, 2002).

7.2 What determines whether GPs have contact with opiate misusers?

The following will be examined in turn:

- GP demographics
- Practice policies
- Remuneration for prescribing methadone
- Role legitimacy and adequacy in providing services to opiate misusers
- GP ratings of the local community drug team (CDT).

7.2.1 GP demographics

Half of the sample (50.5 per cent, 948/1879) had seen an opiate misuser in the previous four weeks.

T-tests and chi-square analyses were conducted to explore whether GPs who saw opiate misusers were different demographically to those who did not. GPs who saw opiate misusers were younger (mean age of 44.2 years versus 45.3 years; t=2.2, df=1289.6, p=0.028), had been qualified as a doctor for a shorter length of time (mean length of time qualified of 20.3 years versus 21.2 years; t=-2.4, df=1832.3, p=0.019), had been working as a GP for a shorter amount of time (mean length of time working as GP of 13.9 years versus 14.8; t=-2.4, df=1844, p=0.018), were more likely to be male (53.7 per cent versus 44.1 per cent; χ²=15.7, df=1, p<0.0005) and were more likely to be working in an urban practice (57.6 per cent) as opposed to suburban (47.4 per cent) or rural (36.7 per cent) (χ²=40.4, df=2, p=0.0005).

7.2.2 Practice policies

GPs were asked a series of questions concerning the policies of their practices (in the form of attitude statements):

- There is a policy for the management of opiate misusers in a formal shared care arrangement with specialist service
- Care of opiate misusers is not part of the work of our practice
- There is a limit on the number of opiate misusers who are patients at the practice
- There is a limit on the hours during which opiate misusers can be seen by a doctor.

A chi-square analysis has been conducted looking at each of these items and whether they determine if GPs see opiate misusers. Opiate misusers were more likely to be seen by GPs whose practice had a policy for the management of opiate misusers (60.9 per cent versus 45 per cent; χ²=33.62, df=1, p<0.0005), care of opiate misusers was part of the work of the practice (62.5 per cent versus 30.9 per cent; χ²=113.29, df=1, p<0.0005) and there was a limit on the number of opiate misusers who are patients in the practice (63 per cent versus 54 per cent; χ²=5.58, df=1, p=0.018). Whether the practice limited the hours during which opiate misusers could be seen by a doctor did not influence whether GPs saw opiate misusers (62.6 per cent versus 55 per cent; χ²=2.26, df=1, p=0.132, ns).

7.2.3 GP remuneration for prescribing methadone

One of the items in the questionnaire asked whether extra remuneration is provided locally for prescribing methadone for illicit opiate misuse. GPs were more likely to see opiate misusers if extra remuneration was provided (65.9 per cent versus 48.6 per cent; χ²=29.7, df=1, p<0.0005).

7.2.4 GP’s role legitimacy, adequacy and support

GPs were asked to rate their views on various aspects of service provision to opiate misusers. The items addressed various aspects of managing and treating opiate misusers within general practice and are based on the three areas of exploring therapeutic commitment of GPs developed by the Maudsley Alcohol Pilot Project (Shaw, 1978).

For each issue, GPs were asked to rate:

- How appropriate they felt it was (exploring role legitimacy)
- How confident they felt in their ability (exploring role adequacy)
- Whether they were currently doing this form of care (exploring role support).

This report presents GP ratings of appropriateness and confidence in relation to four areas of service provision:

- Assess opiate users for dependence
- Prescribe methadone for maintenance
- Prescribe methadone for reduction
- Offer screening for HIV, hep B and hep C.

7.2.4.1 Assessing opiate users for dependence

Appropriateness

Of the GPs who did not see any opiate misusers, the majority rated assessing opiate users for dependence as not at all appropriate (62.1 per cent; 32.6 per cent rated it as somewhat appropriate and only 5.3 per cent rated it as very appropriate).

Of the GPs who saw opiate misusers, a slightly higher proportion felt it was very appropriate (12.2 per cent; 43.8 per cent felt it...
was somewhat appropriate and 44.1 per cent felt it was not at all appropriate. ($\chi^2=53.47, \text{df}=2, p<0.0005$.)

**Confidence**

Of the GPs who did not see any opiate misusers, 68.4 per cent did not feel at all confident (28.1 per cent rated themselves as feeling somewhat confident and only 3.5 per cent were very confident).

Again, among the GPs who saw opiate misusers, more felt confident in their ability (8.4 per cent; 40.4 per cent felt somewhat confident and 50.3 per cent were not at all confident). ($\chi^2=53.94, \text{df}=2, p<0.0005$.)

### 7.2.4.2 Prescribing methadone for maintenance

**Appropriateness**

Of the GPs who did not see any opiate misusers, the majority (67.1 per cent) rated prescribing methadone for maintenance as not at all appropriate (29.1 per cent rated it as somewhat appropriate and only 3.8 per cent rated it as very appropriate).

Of the GPs who saw opiate misusers, a higher proportion felt it was very appropriate (17.5 per cent; 39.4 per cent felt it was somewhat appropriate and 43.2 per cent felt it was not at all appropriate). ($\chi^2=109.49, \text{df}=2, p<0.0005$.)

**Confidence**

Of the GPs who did not see any opiate misusers, 75.7 per cent did not feel at all confident (20.4 per cent rated themselves as feeling somewhat confident and only 3.9 per cent were very confident).

Again, among the GPs who saw opiate misusers, more felt confident in their ability (16.9 per cent; 32.9 per cent felt somewhat confident and 50.2 per cent were not at all confident). ($\chi^2=112.22, \text{df}=2, p<0.0005$.)

### 7.2.4.3 Prescribing methadone for reduction

**Appropriateness**

Of the GPs who did not see any opiate misusers, the majority (68 per cent) rated prescribing methadone for reduction as not at all appropriate (28.4 per cent rated it as somewhat appropriate and only 3.6 per cent rated it as very appropriate).

Of the GPs who saw opiate misusers, a higher proportion felt it was very appropriate (16 per cent; 40.7 per cent felt it was somewhat appropriate and 43.3 per cent felt it was not at all appropriate). ($\chi^2=110.01, \text{df}=2, p<0.0005$.)

**Confidence**

Of the GPs who did not see any opiate misusers, 78.9 per cent did not feel at all confident (18.3 per cent rated themselves as feeling somewhat confident and only 2.7 per cent were very confident).

Again, among the GPs who saw opiate misusers, more felt confident in their ability (15.1 per cent; 32.3 per cent felt somewhat confident and 52.6 per cent were not at all confident). ($\chi^2=121.68, \text{df}=2, p<0.0005$.)

### 7.2.4.4 Offering screening for HIV and hepatitis B and C

The pattern seen previously with the three areas of service provision is not repeated here.

**Appropriateness**

Of the GPs who did not see any opiate misusers, only 26.4 per cent rated offering screening for HIV and hepatitis B and C as not at all appropriate (42.2 per cent rated it as somewhat appropriate and 31.4 per cent as very appropriate).

Among the GPs who saw opiate misusers, almost half (46.8 per cent) felt it was very appropriate (32 per cent felt it was somewhat appropriate and only 21.2 per cent felt it was not at all appropriate). ($\chi^2=35.67, \text{df}=2, p<0.0005$.)

**Confidence**

Of the GPs who did not see any opiate misusers, 29.7 per cent did not feel at all confident (40.5 per cent rated themselves as feeling somewhat confident and 29.8 per cent were very confident).

Among the GPs who saw opiate misusers, more felt confident in their ability (43.9 per cent; 33.3 per cent felt somewhat confident and 22.8 per cent were not at all confident). ($\chi^2=29.56, \text{df}=2, p<0.0005$.)

### 7.2.5 Are role legitimacy and adequacy related to remuneration?

Each of the four areas of service provision (assessing opiate users for dependence, prescribing methadone for maintenance, prescribing methadone for reduction and offering screening for HIV and hepatitis B and C) are discussed in turn.

#### 7.2.5.1 Assessing opiate users for dependence

**Appropriateness**

Where remuneration was provided locally, 14.8 per cent of GPs felt it was very appropriate to assess opiate users for dependence; 43.3 per cent felt it was somewhat appropriate and 42 per cent felt it was not at all appropriate. ($\chi^2=24.90, \text{df}=2, p<0.0005$.)

**Confidence**

Eleven per cent of GPs who were remunerated were very confident in their ability to assess opiate users for dependence;
38.5 per cent were somewhat confident and 50.5 per cent were not at all confident.

Contrastingly, where remuneration was not provided locally, only 5.5 per cent were very confident, 33.3 per cent were somewhat confident and almost 2/3 (61.2 per cent) were not at all confident in their ability to assess opiate users for dependence ($\chi^2=17.62$, df=2, $p<0.0005$).

### 7.2.5.2 Prescribing methadone for maintenance

#### Appropriateness

Where remuneration was provided locally, 22.4 per cent felt it was very appropriate to prescribe methadone for maintenance, 40.8 per cent felt it was somewhat appropriate and 36.8 per cent felt it was not at all appropriate.

Again, the picture is different for GPs who do not receive remuneration. Only 8.2 per cent felt it was very appropriate to prescribe methadone for maintenance, 33.3 per cent felt it was somewhat appropriate and more than half (58.5 per cent) felt it was not at all appropriate ($\chi^2=67.70$, df=2, $p<0.0005$).

#### Confidence

20.1 per cent of GPs who were remunerated felt very confident in their ability to prescribe methadone for maintenance, 34.7 per cent rated themselves as feeling somewhat confident but nearly half (45.2 per cent) were not at all confident.

Again, among the GPs who were not remunerated, less felt confident in their ability (8.5 per cent), 25 per cent felt somewhat confident and almost 2/3 (66.5 per cent) were not at all confident ($\chi^2=53.86$, df=2, $p<0.0005$).

### 7.2.5.3 Prescribing methadone for reduction

#### Appropriateness

Of the GPs who were remunerated, 20.9 per cent rated prescribing methadone for reduction as very appropriate, 43 per cent rated it as somewhat appropriate and 36.1 per cent as not at all appropriate.

Contrastingly, among those who were not remunerated, only 7.5 per cent felt it was very appropriate, 33.2 per cent felt it was somewhat appropriate and over half (59.2 per cent) felt it was not at all appropriate ($\chi^2=71.76$, df=2, $p<0.0005$).

#### Confidence

Of the GPs who were remunerated, 18.6 per cent felt very confident in their ability to prescribe methadone for reduction, 34.7 per cent rated themselves as feeling somewhat confident and 46.7 per cent were not at all confident.

Among the GPs who did not receive remuneration, only 7.3 per cent felt confident in their ability, 23.3 per cent felt somewhat confident and over 2/3 (69.5 per cent) were not at all confident ($\chi^2=61.46$, df=2, $p<0.0005$).

### 7.2.5.4 Offering screening for HIV and hepatitis B and C

The pattern seen previously with the three areas of service provision is not repeated here.

#### Appropriateness

Among the GPs who were remunerated, half (50.2 per cent) rated offering screening for HIV, Hepatitis B and Hepatitis C as very appropriate, 31.7 per cent rated it as somewhat appropriate and only 18.2 per cent rated it as not at all appropriate.

Of the GPs who did not receive remuneration, 37.2 per cent felt it was very appropriate, 38.7 per cent felt it was somewhat appropriate and 24.1 per cent felt it was not at all appropriate ($\chi^2=17.11$, df=2, $p<0.0005$).

#### Confidence

Where GPs received remuneration, 45.8 per cent felt confident in their ability to offer screening for blood-borne viruses, 34.6 per cent rated themselves as feeling somewhat confident and 19.7 per cent were not at all confident.

Among GPs who did not receive any remuneration, 35.7 per cent felt confident in their ability, 37.5 per cent felt somewhat confident and 26.8 per cent were not at all confident ($\chi^2=11.55$, df=2, $p=0.003$).

### 7.3 GP ratings of local community drug teams

Where services existed locally, GPs were asked to rate their local community drugs team (CDT).

Of the GPs who had been in contact with an opiate misuser in the previous four weeks, 22 per cent were not happy with the local CDT (5.3 per cent rated it as very poor and 17 per cent rated it as poor), over 40 per cent (41.9 per cent) rated the local CDT as satisfactory and over on-third (35.8 per cent) of GPs were happy with the local CDT (23.8 per cent rated it as good and 12 per cent as very good) ($\chi^2=16.20$, df=4, $p=0.003$).

#### GPs who had seen an opiate misuser

Half of the GPs (50.5 per cent; 948/1,877) had seen at least one opiate misuser in the previous four weeks. Two GPs are excluded.
from further analyses since they also worked in a drug dependency unit or drug team clinic. A further four were excluded because although they had seen at least one opiate misuser in the previous four weeks, they did not specify the total number they had seen. The remaining 942 GPs had seen a total of 3,881 opiate misusers in the four-week period, giving a mean of 4.12 per GP (range = 1–60).

Half of the GPs (50.5 per cent; 478/946) who attended an opiate misuser had prescribed substitute opiates in at least one case.

8.1 What determines whether GPs prescribe?

The following will be examined in turn in relation to whether GPs prescribed:

- GP demographics
- Practice policies
- Remuneration for prescribing methadone
- Role legitimacy and adequacy in providing services to opiate misusers
- GP ratings of the local CDT.

8.1.1 GP demographics

When comparing GPs who prescribed with those who did not, they did not differ on age (those who prescribed had a mean age of 44.2 years versus 45.2 for those who did not prescribe; t=0.02, df=639, p=0.99), years qualified as a doctor (20.2 years versus 20.3; t=0.15, df=914.4, p=0.88), years working as a GP (13.8 versus 14.0; t=-0.36, df=913.5, p=0.72) or practice location (49.5 per cent of GPs from urban practices prescribed, 51.8 per cent from rural practice prescribed and 56.5 per cent from rural practices prescribed; χ²=1.80, df=2, p=0.41). However, more male GPs prescribed than female GPs (53 per cent of male GPs prescribed versus 44.6 per cent of female GPs; χ²=5.54, df=1, p=0.02).

8.1.2 Practice policies

A chi-square analysis has been conducted looking at each of the four practice policy items and whether they determine if GPs prescribe substitute opioids. GPs were more likely to prescribe if there was a policy for the management of opiate misusers (59.3 per cent versus 36.8 per cent; χ²=36.19, df=1, p<0.0005), care of opiate misusers was part of the work of the practice (59.2 per cent versus 20.1 per cent; χ²=65.79, df=1, p<0.0005), there was a limit on the number of opiate misusers who are patients at the practice (73.7 per cent versus 48.9 per cent; χ²=25.58, df=1, p<0.0005) and there was a limit on the hours during which opiate misusers could be seen by a doctor (68.7 per cent versus 52.2 per cent; χ²=6.50, df=1, p=0.011).

8.1.3 Remuneration for prescribing methadone

Where remuneration was provided locally for prescribing methadone for illicit opiate misuse, GPs had a higher mean patient caseload; almost twice as many opiate misusers (6.55 as opposed to 3.70; t=2.90, df=229, p=0.004). GP s were also much more likely to prescribe if remuneration was provided (67.3 per cent versus 45.4 per cent; χ²=29.09, df=1, p<0.0005).

8.1.4 Role legitimacy and adequacy

Each of the four areas of service provision (assess opiate users for dependence, prescribe methadone for maintenance, prescribe methadone for reduction and offer screening for HIV and hepatitis B and C) are discussed in turn.

8.1.4.1 Assessing opiate users for dependence

Appropriateness

Of the GPs who did not prescribe, over half (50.7 per cent) rated assessing opiate users for dependence as not at all appropriate (42.7 per cent rated it as somewhat appropriate and 6.6 per cent as very appropriate).

Of the GPs who prescribed, a higher proportion felt it was very appropriate (17.4 per cent; 45.1 per cent felt it was somewhat appropriate but over one-third (37.6 per cent) felt it was not at all appropriate). (χ²=25.87, df=2, p<0.0005.)

Confidence

Of the GPs who did not prescribe, 73.7 per cent did not feel at all confident (21.5 per cent rated themselves as feeling somewhat confident and only 4.8 per cent were very confident).

Again, among the GPs who prescribed, more felt confident in their ability (13.1 per cent; 43.3 per cent felt somewhat confident but 43.6 per cent were not at all confident). (χ²=20.92, df=2, p<0.0005.)

8.1.4.2 Prescribing methadone for maintenance

Appropriateness

Of the GPs who did not prescribe, the majority (69 per cent) rated prescribing methadone for maintenance as not at all appropriate (28 per cent rated it as somewhat appropriate and 2.9 per cent as very appropriate).

Of the GPs who prescribed, a higher proportion felt it was very appropriate (31.5 per cent; 50.6 per cent felt it was somewhat appropriate and 17.8 per cent felt it was not at all appropriate). (χ²=231.10, df=2, p<0.0005.)

Confidence

Of the GPs who did not prescribe, 73.7 per cent did not feel at all confident (21.5 per cent rated themselves as feeling somewhat confident and only 4.8 per cent were very confident).
Again, among the GPs who prescribed, more felt very confident in their ability (28.5 per cent; 44.1 per cent felt somewhat confident and 27.4 per cent were not at all confident).

\( \chi^2=171.33, \text{df}=2, p<0.0005. \)

8.1.4.3 Prescribing methadone for reduction

**Appropriateness**

Of the GPs who did not prescribe, the majority (67.6 per cent) rated prescribing methadone for reduction as not at all appropriate (30.1 per cent rated it as somewhat appropriate and only 2.4 per cent rated it as very appropriate).

Of the GPs who prescribed, a higher proportion felt it was very appropriate (29 per cent; 51.3 per cent felt it was somewhat appropriate and 19.7 per cent felt it was not at all appropriate).

\( \chi^2=206.83, \text{df}=2, p<0.0005. \)

**Confidence**

Of the GPs who did not prescribe, 76.6 per cent did not feel at all confident (18.8 per cent rated themselves as feeling somewhat confident and only 4.6 per cent were very confident).

Again, among the GPs prescribed, more felt confident in their ability (25.2 per cent; 45.4 per cent felt somewhat confident and 29.4 per cent were not at all confident).

\( \chi^2=171.99, \text{df}=2, p<0.0005. \)

8.1.4.4 Offering screening for HIV and hepatitis B and C

The pattern seen with the three previous areas of service provision is not repeated here.

**Appropriateness**

Of the GPs who did not prescribe, only 24.7 per cent rated offering screening for HIV, hepatitis B and hepatitis C as not at all appropriate (36.3 per cent rated it as somewhat appropriate and 39 per cent as very appropriate).

Among the GPs who prescribed, over half (54.4 per cent) felt it was very appropriate (27.9 per cent felt it was somewhat appropriate and only 17.7 per cent felt it was not at all appropriate).

\( \chi^2=18.31, \text{df}=2, p<0.0005. \)

**Confidence**

Of the GPs who did not prescribe, 27.5 per cent did not feel at all confident (35.7 per cent rated themselves as feeling somewhat confident and 27.5 per cent were very confident).

Among the GPs who prescribed, half (50.7 per cent) felt confident in their ability (31.2 per cent felt somewhat confident and 18.1 per cent were not at all confident).

\( \chi^2=16.30, \text{df}=2, p<0.0005. \)

8.2 GP ratings of the local community drug team

8.2.1 Do GP ratings of the local CDT determine the opiate misuser caseload?

Where the service existed locally, GPs were asked to rate their local CDT. Figure 1 shows the mean number of opiate misusers seen by GPs who rated their local CDT.

A u-shaped curve can be seen; GPs who rated the local CDT as very poor had the highest opiate misuser caseload of 6.7 opiate misusers whereas those who rated the service as very good only saw a mean of 5.7. Those rating the local CDT as poor saw a mean of 3.6, whereas those who rated the service as good saw a mean of 4.8 opiate misusers.

\( f=2.45, \text{df}=4,764, p=0.045. \)

8.2.2 Do GP ratings of the local CDT affect whether GPs prescribed?

Of the GPs who prescribed, 23.9 per cent gave a negative rating of their local CDT (5.4 per cent rated the local CDT as very poor and 18.5 per cent rated it as poor). Around one-third of GPs (30.3 per cent) were satisfied with the CDT and almost half (45.8 per cent) were happy with the local CDT (27 per cent rated it as good and 18.8 per cent rated it as very good).

Among GPs who did not prescribe, one-third (31.3 per cent) were not happy with their local CDT (7.9 per cent rated it as very poor and 23.4 per cent rated it as poor). One third (33.9 per cent) were satisfied with the local CDT and the remaining one-third were happy (24.9 per cent rated it as good and ten per cent rated it as very good).

\( \chi^2=15.33, \text{df}=4, p=0.045. \)

9 GPs who prescribed

In the four weeks previous to the survey, 50.5 per cent (948/1877) of GPs in the sample had seen at least one opiate misuser. Of those who had seen at least one opiate misuser, 50.5 per cent (478/948) had prescribed substitute opiates in at least one case. Four hundred and fifty four GPs specified the total number of opiate misusers they prescribed to and a total of 1,699 opiate misusers were prescribed substitute opiates by
these 454 GPs, giving a mean of 3.7 opiate misusers per GP (range = 1-48).

GPs were also asked to provide data on the substitute opioids they had prescribed in the previous four weeks. Three hundred and ninety five GPs provided details on the prescriptions. Figure 2 shows the proportion of GPs in the sample and the number of opiate misusers they prescribed to.

9.1 Substitute opioids prescribed

The total of substitute opioids prescribed was 1,442. Details of all substitute opioids prescribed are outlined in Table 3 but, since the majority of prescriptions were for either methadone, dihydrocodeine or buprenorphine, all subsequent analyses focus on these three drugs.

9.2 Remuneration and drugs prescribed

No significant difference was found between whether GPs were offered remuneration and the drugs they prescribed (where remuneration was provided, 92.3 per cent prescribed methadone, 5.4 per cent prescribed buprenorphine and 2.3 per cent prescribed dihydrocodeine; where remuneration was not provided, 84.3 per cent prescribed methadone, 7.9 per cent prescribed buprenorphine and 7.9 per cent prescribed dihydrocodeine; \( \chi^2 = 5.85, \text{df}=2, p=0.054 \)).

10 Role legitimacy and adequacy – composite scores

As stated in sections seven and eight, GPs were asked to rate their views on areas of service provision to opiate misusers. For each activity, they were asked to rate how appropriate they felt this activity was for a GP to perform (exploring role legitimacy) and secondly, how confident they felt in their ability to provide the service (exploring role adequacy). For the purpose of this section of the report, these ratings have been collapsed in to composite scores, where a score of zero means that they do not feel the activity is at all appropriate for a GP to provide and they are not at all confident in their ability to provide it and a score of four means that they feel it is very appropriate for them to provide and are very confident in their ability to provide it. Table 4 presents the scoring in more detail.

In this section of the report, two areas of service provision are presented; prescribing methadone for reduction and prescribing methadone for maintenance. Four issues are looked at:

- Remuneration
- Whether GPs saw an opiate misuser
- Whether GPs prescribed
- Whether this was in shared care.

10.1 Remuneration

GPs’ combined ratings of their confidence and the appropriateness of prescribing methadone for reduction and maintenance was more favourable when remuneration was provided.

<table>
<thead>
<tr>
<th>Original responses</th>
<th>Composite score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all appropriate and not at all confident</td>
<td>0</td>
</tr>
<tr>
<td>Not at all appropriate and somewhat confident</td>
<td>1</td>
</tr>
<tr>
<td>Not at all confident and somewhat appropriate</td>
<td>1</td>
</tr>
<tr>
<td>Not at all appropriate and very confident</td>
<td>2</td>
</tr>
<tr>
<td>Not at all confident and very appropriate</td>
<td>2</td>
</tr>
<tr>
<td>Somewhat appropriate and somewhat confident</td>
<td>2</td>
</tr>
<tr>
<td>Somewhat appropriate and very confident</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat confident and very appropriate</td>
<td>3</td>
</tr>
<tr>
<td>Very appropriate and somewhat confident</td>
<td>3</td>
</tr>
<tr>
<td>Very appropriate and very confident</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 3: Substitute opioids prescribed

Table 4: Creating composite scores
10.1.1 Prescribing methadone for reduction
GPs were more likely have a high composite score for prescribing methadone for reduction if remuneration was provided; only 12.9 per cent of those scoring zero, 17.8 per cent of those scoring one and 27.2 per cent of those scoring two received remuneration whereas 38.9 per cent of those scoring three and 44.7 per cent of those scoring four received remuneration ($\chi^2=82.37, df=4, p=0.0005$).

10.1.2 Prescribing methadone for maintenance
As was seen for prescribing methadone for reduction, GPs were more likely have a high composite score for prescribing methadone for maintenance if remuneration was provided; only 13.2 per cent of those scoring zero, 18.8 per cent of those scoring one and 25.5 per cent of those scoring two received remuneration whereas 37.1 per cent of those scoring three and 44 per cent of those scoring four received remuneration ($\chi^2=74.91, df=4, p=0.0005$).

10.1.3 Contact with opiate misusers
GPs' combined ratings of their confidence and the appropriateness of prescribing methadone for reduction and maintenance was more likely to be high if they had seen an opiate misuser in the previous four weeks.

10.1.4 Prescribing methadone for reduction
GPs were more likely have a high composite score for prescribing methadone for reduction if they had seen an opiate misuser in the previous four weeks; only 39.2 per cent of those scoring zero had seen an opiate misuser, whereas 52 per cent of those scoring one, 65.2 per cent of those scoring two, 80.2 per cent of those scoring three and 92.1 per cent of those scoring four had seen an opiate misuser ($\chi^2=151.39, df=4, p=0.0005$).

10.1.5 Prescribing methadone for maintenance
As was seen with prescribing methadone for reduction, GPs were more likely to have a high composite score for prescribing methadone for maintenance if they had seen an opiate misuser in the previous four weeks; only 39.3 per cent of those scoring zero had seen an opiate misuser whereas 52 per cent of those scoring one, 62.8 per cent of those scoring two, 78 per cent of those scoring three and 90.6 per cent of those scoring four had seen an opiate misuser ($\chi^2=143.40, df=4, p=0.0005$).

10.2 Prescribing substitute opioids
GPs' combined ratings of their confidence and the appropriateness of prescribing methadone for reduction and maintenance was more likely to be high if they had prescribed substitute opioids.

10.2.1 Prescribing methadone for reduction
GPs were more likely have a high composite score for prescribing methadone for reduction if they had prescribed substitute opioids; only 18.5 per cent of those scoring zero had prescribed, whereas 48.1 per cent of those scoring one, 69.3 per cent of those scoring two, 84.4 per cent of those scoring three and 95.7 per cent of those scoring four had prescribed ($\chi^2=243.52, df=4, p=0.0005$).

10.2.2 Prescribing methadone for maintenance
As was seen with prescribing methadone for reduction, GPs were more likely have a high composite score for prescribing methadone for maintenance if they had prescribed; only 16.3 per cent of those scoring zero had prescribed, whereas 47.7 per cent of those scoring one, 68.7 per cent of those scoring two, 85.9 per cent of those scoring three and 93.4 per cent of those scoring four had seen an opiate misuser ($\chi^2=263.59, df=4, p=0.0005$).

10.3 Shared care arrangements
When providing the prescription information, GPs were asked to indicate in each case whether the prescribing was part of a shared care arrangement. Unlike the other examples described, no data has yet been presented in this report on shared care. Before the data relating to the composite scores are presented, some basic analyses relating to shared care will be presented.

Shared care arrangements accounted for 63.7 per cent of all prescriptions detailed. T-tests and chi square analyses were conducted to explore whether GPs who prescribed using shared care arrangements were different demographically to those who did not. GPs who used shared care arrangements were older (mean age of 44.8 years versus 43.8 years; $t=2.3, df=854, p=0.020$), had been working as a GP for longer (mean length of time qualified as a GP of 14 years versus 12.6; $t=3.9, df=1205, p=0.0005$) and females were more likely prescribe using shared care than males (77.5 per cent versus 60.1 per cent; $\chi^2=30.92, df=1, p=0.0005$). There was no significant difference between those who prescribed using shared care and those who did not on the length of time qualified as a GP (20.65 for those using shared care versus 20.2 for those not using shared care; $t=1.1, df=1102, p=0.29, ns$) or practice location (68.6 per cent of those in urban practices, 68.3 per cent of those in suburban practices and 70.9 per cent of those in rural practices prescribed using share care arrangements; $\chi^2=0.13, df=2, p=0.94, ns$). More information on shared care prescribing is presented in sections 11 and 12.

Looking at the composite scores, the pattern seen with the other three examples is not repeated for shared care. GPs were more likely to have prescribed without using a shared care arrangement if the combined ratings of their confidence and the
appropriateness of prescribing methadone for reduction and maintenance was either zero or four.

10.3.1 Prescribing methadone for reduction

Only 54.9 per cent of GPs scoring zero and half (50.8 per cent) of those scoring four had prescribed using shared care arrangements, whereas 79.4 per cent of those scoring one, 75.6 per cent of those scoring two and 71.2 per cent of those scoring three had prescribed using shared care ($\chi^2=19.99, \text{df}=4, p=0.001$).

10.3.2 Prescribing methadone for maintenance

As was seen with prescribing methadone for reduction, just over half (52.3 per cent) of those scoring zero and just over half (54.7 per cent) of those scoring four had prescribed using shared care arrangements, whereas 78.7 per cent of those scoring one, 74.6 per cent of those scoring two and 72.1 per cent of those scoring three had prescribed using shared care ($\chi^2=16.75, \text{df}=4, p=0.002$).

11 Regional breakdowns of prescribed drugs

This section of the report will examine:

- Regional breakdown of drugs prescribed
- Variations in prescribing within shared care by region
- Variations in dispensing by region
- Variations in doses prescribed by region.

11.1 Regional variations in drugs prescribing

As was discussed in section nine, nationally, methadone accounted for 86.9 per cent of all the prescriptions, followed by dihydrocodeine (accounting for 8.4 per cent of all prescriptions) and buprenorphine (accounting for 4.2 per cent of all prescriptions). Table 5 shows the drugs prescribed by GPs in each of the NTA regions.

In all but one NTA region, at least 80 per cent of substitute opioid prescribing was for methadone. The East Midlands region was the exception; only 53.5 per cent of the substitute opioid prescribing was for methadone and a far higher proportion of substitute opioid prescribing was for either buprenorphine or dihydrocodeine than seen in the other eight NTA regions.

Dihydrocodeine was the second most common drug prescribed in London, the South West, West Midlands, the North West, and Yorkshire and Humberside regions. The latter two regions also had a higher proportion of prescriptions for dihydrocodeine than seen nationally.

Buprenorphine was the second most commonly prescribed drug in two NTA regions: East Anglia and the East Midlands. The North East and South East regions prescribed an equal amount of dihydrocodeine and buprenorphine.

Figure 3 shows the proportion of GPs prescribing the three main substitute opioids by NTA region.

Table 5: Regional variations in drugs prescribed (EA = East Anglia, EM = East Midlands, LON = London, NE = North East, NW = North West, SE = South East, WM = West Midlands, YH = Yorkshire and Humberside)

<table>
<thead>
<tr>
<th>Region</th>
<th>Methadone</th>
<th>Dihydrocodeine</th>
<th>Buprenorphine</th>
<th>Morphine sulphate</th>
<th>Codeine</th>
<th>Dextropropoxyphene</th>
</tr>
</thead>
<tbody>
<tr>
<td>EA</td>
<td>93.3% (111/119)</td>
<td>1.7% (2/119)</td>
<td>5.0% (6/119)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>EM</td>
<td>53.5% (38/71)</td>
<td>19.7% (14/71)</td>
<td>26.8% (19/71)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>LON</td>
<td>97.1% (169/174)</td>
<td>2.3% (4/174)</td>
<td>-</td>
<td>0.6% (1/174)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NE</td>
<td>93% (80/86)</td>
<td>3.5% (3/86)</td>
<td>3.5% (3/86)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NW</td>
<td>81.5% (344/422)</td>
<td>13.7% (58/422)</td>
<td>4.3% (18/422)</td>
<td>-</td>
<td>0.5% (2/422)</td>
<td>-</td>
</tr>
<tr>
<td>SE</td>
<td>94.7% (126/133)</td>
<td>1.5% (2/133)</td>
<td>1.5% (2/133)</td>
<td>2.3% (3/133)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>SW</td>
<td>88.7% (181/204)</td>
<td>7.8% (16/204)</td>
<td>2.9% (6/204)</td>
<td>-</td>
<td>0.5% (1/204)</td>
<td>-</td>
</tr>
<tr>
<td>WM</td>
<td>91.1% (102/112)</td>
<td>5.4% (6/112)</td>
<td>2.7% (3/112)</td>
<td>-</td>
<td>-</td>
<td>0.9% (1/112)</td>
</tr>
<tr>
<td>YH</td>
<td>84.3% (102/121)</td>
<td>13.2% (16/121)</td>
<td>2.5% (3/121)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Figure 3: Prescribing of three main drugs by NTA region
11.2 Variations in prescribing within shared care by region

Section ten presented national data relating to shared care. Figure 4 shows the level of shared care prescribing by NTA region.

As can be seen from the chart, there was wide variation in the level of shared care prescribing by region. While East Anglia, East Midlands, London, the North East and North West regions had around 60 per cent of prescriptions using shared care arrangements (64.4, 62.3, 62.8, 64.7 and 59.1 per cent respectively), the South East, South West and West Midlands regions had over 70 per cent of prescriptions using shared care arrangements (76, 78.9 and 77.1 per cent respectively). The exception is Yorkshire and Humber, where less than one-third of prescriptions (30 per cent) used a shared care arrangement. The chi-square analysis shows the difference between NTA regions in prescribing within shared care to be highly significant ($\chi^2=99.06$, df=8, $p<0.0005$).

There is wide variation in substitute prescribing and shared care arrangements by NTA region. To study whether there is regional variation in dispensing arrangements and doses prescribed, data relating to these prescriptions is described. Since methadone syrup was the most common prescription, only data relating to this is discussed.

11.3 Variations in dispensing by region

For the purposes of this report, the dispensing arrangements have been split into three categories; a weekly pickup includes those picked up once a week and less frequently, a pickup of several times per week includes those dispensed two, three or four times a week, and daily dispensing includes pickups of five or more times per week. Figure 5 shows the regional variations in dispensing arrangements.

Daily dispensing was the most popular pickup arrangement in the following NTA regions: North East (71.3 per cent of all prescriptions), South West (68.7 per cent) and East Midlands (62.1 per cent).

Single weekly pickups were the most popular dispensing arrangement for GPs in London (60.4 per cent), the West Midlands (57.1 per cent), East Anglia (51 per cent), and the North West (44.5 per cent).

GPs from the South East were almost equally prescribing daily and weekly pickups (47.3 and 42.9 per cent respectively) as were GPs from Yorkshire and Humber (48.5 and 41.4 per cent respectively). Although in both of these regions, the proportion of GPs prescribing daily dispensing is slightly higher.

The chi-square analysis shows the difference between dispensing arrangements by NTA regions care to be highly significant ($\chi^2=165.82$, df=16, $p<0.0005$).

11.4 Variations in doses prescribed by region

Figure 6 shows the regional variations in mean doses prescribed. Across all regions, the mean daily dose prescribed is low; the doses range from 29.2mg to 41.1mg.

Only GPs from the North West and East Anglia prescribed an average daily dose of over 40mg (41.1mg and 40.7mg respectively).

GPs from London and the North East prescribed an average daily dose of between 35 and 40mg (35.4mg and 38.7mg respectively).

In four NTA regions the mean daily dose was between 30 and 35 mg (Yorkshire and Humber = 30.8mg; South East = 32.4mg; West Midlands = 33.1mg; South West = 34.1mg).

GPs from one NTA region, the East Midlands, prescribed a mean daily dose of under 30mg (29.2mg).

The one-way analysis of variance shows the difference in doses prescribed between NTA regions to be statistically significantly
different ($F=4.40$, df=8,1114, $p<0.0005$) and post hoc tests reveal the differences between East Anglia and Yorkshire and Humber (p=0.027), North West and South East (p=0.025), North West and South West (p=0.021), North West and West Midlands (p=0.045), and North West and Yorkshire and Humber (p=0.001) to be significantly different.

12 Prescribing and dosing

This section reports on:

- The variations in prescribing for the three main drugs prescribed
- The small cohort of GPs who prescribed more than one drug
- Whether GPs’ ratings of the local CDT determine if they prescribed within shared care.

12.1 Methadone prescriptions

Methadone prescriptions accounted for 1,253 of the 1,442 prescriptions. In 1,247 cases, information was also provided on the form of the drug prescribed.

As can be seen from Table 6, nearly all methadone prescriptions were in the syrup form. To enable comparison, each form is summarised.

12.1.1 Syrup prescriptions

The mean daily dose was lower than for tablets or ampoules but the range of doses varied hugely if the form prescribed was syrup. As a proportion of methadone syrup prescriptions, 44.9 per cent of pickups were daily and over two-thirds used a shared care arrangement.

12.1.2 Tablet prescriptions

The most common form of pickup for tablet prescriptions was weekly pickup (59.4 per cent) but less than half of all tablet prescriptions (48.6 per cent) used a shared care arrangement.

12.1.3 Ampoule prescriptions

Over two-thirds of pickups (70.6 per cent) for ampoule prescriptions were for weekly pickup and just over half (55.6 per cent) used a shared care arrangement.

12.1.4 Dihydrocodeine prescriptions

The total number of prescriptions for dihydrocodeine was 121. As can be seen from Table 6, the mean daily dose was 212.6 mg (range 30–960mg). Most pickups were on a weekly basis (89.6 per cent) and only 26.1 per cent of all dihydrocodeine prescriptions used a shared care arrangement.

12.2 Buprenorphine prescriptions

Sixty prescriptions were for buprenorphine. As can be seen from Table 6, the mean daily dose was 5.8mg, almost half of all prescriptions were for a weekly pickup and almost 2/3 (59.3 per cent) used a shared care arrangement.

12.3 Do GPs who prescribe dihydrocodeine not prescribe methadone?

Thirty-seven GPs prescribed more than one drug. 34 GPs prescribed two different drugs and three GPs prescribed three different drugs. The combinations of drugs prescribed by these GPs are summarised in Table 7.

<table>
<thead>
<tr>
<th>Form of drug</th>
<th>%</th>
<th>Daily dose (mg)</th>
<th>Pickups per week</th>
<th>Shared care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>Range</td>
<td>Daily</td>
</tr>
<tr>
<td>Methadone syrup</td>
<td>95.7%</td>
<td>36.5</td>
<td>1–305</td>
<td>44.9%</td>
</tr>
<tr>
<td>Methadone tablet</td>
<td>2.8%</td>
<td>41.3</td>
<td>10–90</td>
<td>21.9%</td>
</tr>
<tr>
<td>Methadone ampoule</td>
<td>1.4%</td>
<td>44.6</td>
<td>5–80</td>
<td>23.5%</td>
</tr>
<tr>
<td>Dihydrocodeine tablet</td>
<td></td>
<td>—</td>
<td>212.6</td>
<td>6.1%</td>
</tr>
<tr>
<td>Buprenorphine tablet</td>
<td>—</td>
<td>5.8</td>
<td>0.4–16</td>
<td>42%</td>
</tr>
</tbody>
</table>

Table 6: Details of methadone prescribed by form
Seventeen GPs prescribed dihydrocodeine and another drug and in 16 cases, where GPs prescribed dihydrocodeine, they also prescribed methadone.

12.4 Do GP ratings of the local CDT influence the use of shared care arrangements?

As can be seen in Figure 7, GPs who rated the local CDT as very poor were less likely to have prescribed using a shared care arrangement. Only 30 per cent of GPs who rated their local CDT as very poor prescribed using shared care arrangements, whereas 77.9 per cent of those who rated it as very good used shared care (52.9 per cent of those who rated it as poor used shared care, 72.8 per cent of those who rated it as satisfactory used shared care and 73.5 per cent of GPs rating the local CDT as good used shared care). The chi-square analysis shows the difference between ratings of the local CDT and prescribing within shared care to be highly significant \( \chi^2=26.10, \text{ df}=4, p<0.0005 \).

13 Overview and preliminary conclusions

13.1 Who sees opiate misusers?

Half the GPs (50.5 per cent) had seen at least one opiate misusing patient during the previous four weeks. A total of 3,881 opiate misusers had been seen by these GPs giving a mean patient caseload of four per GP. We investigated whether GPs who see opiate misusers were different to those who did not. Each of the areas looked at in the report will be summarised in turn for ease of reading.

13.1.1 Demographics

GPs who were in contact with opiate misusers were demographically different to those who were not; they are on average one year younger (average age of 44 years), have been qualified for a year less (average of 20 years), working as a GP for a year less (average of 14 years), were more likely to be male and more likely to be working in an urban practice (as opposed to a suburban or rural practice).

13.1.2 Practice policies

Most practice policies determine whether GPs see opiate misusers; where there is a policy for the management of opiate misusers, where care of opiate misusers is part of the work of the practice and where there is a limit on the number of opiate misusers who are patients at the practice, GPs are more likely to see opiate misusers. Whether the practice limited the hours during which opiate misusers could be seen by a doctor did not influence whether opiate misusers were seen.

13.1.3 Remuneration

The provision of remuneration for prescribing methadone is associated with greater involvement by GPs in seeing opiate misusers. Where it is offered, GPs saw on average twice as many opiate misusers. The availability of remuneration also influences GPs’ views on the appropriateness and confidence in their ability to provide services (this is summarised in section 13.2).

13.1.4 Service provision

For each of the four areas of service provision (assessing opiate misusers for dependence, prescribing methadone for maintenance, prescribing methadone for reduction, and offering screening for HIV and hepatitis B and C), GPs who saw opiate misusers rated the service as more appropriate and reported feeling more confident. However, while they rated the services more favourably than those who did not attend an opiate misuser, for the first three services, the proportion rating the services as inappropriate is still quite high; 44.1 per cent thought it was inappropriate to assess opiate misusers for dependence, 43.2 per cent felt it was not appropriate to prescribe methadone for maintenance and 43.3 per cent felt it was in inappropriate to prescribe methadone for reduction. An even higher proportion were lacking in confidence

<table>
<thead>
<tr>
<th>Combination of drugs prescribed</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone and buprenorphine</td>
<td>18</td>
</tr>
<tr>
<td>Methadone and dihydrocodeine</td>
<td>13</td>
</tr>
<tr>
<td>Buprenorphine and dihydrocodeine</td>
<td>1</td>
</tr>
<tr>
<td>Methadone and morphine sulphate</td>
<td>2</td>
</tr>
<tr>
<td>Methadone, buprenorphine and dihydrocodeine</td>
<td>2</td>
</tr>
<tr>
<td>Methadone, dihydrocodeine and codeine</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 7: Combinations of drugs prescribed
in their ability to provide these services – over half (50.3 per cent, 50.2 per cent and 52.6 per cent respectively). Almost half of the GPs who attended an opiate misuser rated offering screening for blood-borne viruses favourably (46.8 per cent rated it as very appropriate and 43.9 per cent felt very confident in their ability to provide the service).

13.1.5 Ratings of the local community drug team
Nearly 80 per cent of GPs who saw opiate misusers were satisfied to some extent (ratings of satisfied to very good) with their local CDT; 72.5 per cent of those who did not attend an opiate misuser were satisfied.
Among those who attended an opiate misuser, those who rated the local CDT as either very poor or very good had a higher mean patient caseload than those who were more ambivalent to the service.

13.2 How does remuneration affect role legitimacy and adequacy?
For each of the four areas of service provision (assess opiate misusers for dependence, prescribe methadone for maintenance, prescribe methadone for reduction, offer screening for HIV and hepatitis B and C), GPs who were remunerated rated the service as more appropriate and reported feeling more confident.
However, for the first three services, even among those who were remunerated, over one-third still felt it was not at all appropriate for GPs to be providing the service (42, 36.8 and 36.1 per cent respectively). Even more striking among those who were remunerated is the proportion of GPs who are not at all confident to provide the service (50.5, 45.2 and 46.7 per cent respectively).
Half of those who were remunerated (50.2 per cent) rated offering screening for blood-borne viruses as very appropriate and almost half (45.8 per cent) reported feeling very confident in their ability to provide the service.

13.3 Who prescribes to opiate misusers?
Half of the GPs (50.5 per cent) who had seen an opiate misuser had prescribed substitute opioids in at least one case. A total of 1,699 opiate misusers were prescribed substitute opioids, giving a mean of four opiate misusers per GP. We looked at whether GPs who prescribes are different to those who did not.

13.4 Demographics
Prescribing GPs did not differ from non-prescribers in age, years qualified, years working as a GP or practice location. However, male GPs were more likely to prescribe than females (53 per cent versus 44.6 per cent).

13.4.1 Practice policies and remuneration
The policies of the practice also determine whether GPs prescribe; GPs are more likely to prescribe where there is a policy for the management of opiate misusers, where care of opiate misusers is part of the work of the practice, where there is a limit on the number of opiate misusers who are patients at the practice and where there is a limit on the hours during which opiate misusers can be seen by a doctor. GPs were also far more likely to prescribe if remuneration was provided locally for prescribing methadone.

13.4.1.1 Service provision
For each of the four areas of service provision (assess opiate misusers for dependence, prescribe methadone for maintenance, prescribe methadone for reduction, offer screening for HIV and hepatitis B and C), GPs who prescribed echoed those who attended an opiate misuser in that they rated the service as more appropriate and reported feeling more confident.
However, while GPs who prescribed rated the services more favourably than those who did not prescribe, over one-third (37.6 per cent) still thought it was inappropriate to assess opiate misusers for dependence and over 40 per cent (43.6 per cent) were not at all confident.
While less than 20 per cent of those who prescribed felt it was not appropriate to prescribe methadone for maintenance (17.8 per cent) or reduction (19.7 per cent), nearly one-third were not at all confident to prescribe methadone for maintenance (27.4 per cent) or reduction (29.4 per cent).
Among GPs who prescribed, under 20 per cent rated offering screening for blood-borne viruses unfavourably (17.7 per cent rated it as not at all appropriate and 18.1 per cent were not at all confident in their ability to provide the service).

13.4.1.2 Ratings of CDTs
GPs who prescribed mirrored the views of GPs who attended an opiate misuser in that nearly 80 per cent (76.1 per cent) were satisfied to some extent (rating of satisfied to very good) with their local CDT. Similarly, non-prescribers echoed the views of those who did not attend an opiate misuser; almost 70 per cent of those who did not prescribe (68.8 per cent) were satisfied with their local CDT.

13.5 How well does the prescribing accord with national guidance?
13.5.1 Drug and form
A total of 1,442 substitute opioids were prescribed, of which almost 90 per cent (86.9 per cent) were for methadone. Almost all methadone prescribed (95.7 per cent) was in oral form; only a small proportion of methadone scripts were for a non-oral form.
GP prescribing of opioids to opiate-dependent patients in 2001: Secondary analyses of data collected during a national survey of general practitioners in England and Wales in mid-2001

(2.8 per cent were for tablets and 1.4 per cent for ampoules). Dihydrocodeine scripts made up 8.4 per cent of the drugs prescribed and prescribing of buprenorphine accounted for a further 4.2 per cent of all opioids prescribed; the remaining drugs prescribed made up less than one per cent. As in the main section of the report, only the three most common drugs prescribed will be discussed.

In all but one region, methadone prescribing accounts for at least 80 per cent of the drugs prescribed; the East Midlands being the exception, where only just over half of the drugs prescribed were for methadone.

13.5.1.1 Dose
Since the majority of all prescribing was for oral methadone, this section focuses on these prescriptions. The mean daily dose of 36.5mg was seriously worrying and indicates that this is not effective maintenance prescribing; either it provides evidence for a huge amount of slow dose reduction detoxing, or the maintenance dosing is too low.

Regionally, among oral methadone prescriptions, there is wide variation in the mean daily dose prescribed and across all regions, the mean daily dose prescribed is low (doses range from 29.2mg to 41.1mg). Only GPs from The North West and East Anglia prescribed an average daily dose of just over 40mg. Those from London and the North East prescribed between 35 and 40mg. For GPs from Yorkshire and Humberside, the West Midlands, the South East and the South West, the mean daily dose was between 30 and 35mg. GPs from the East Midlands prescribed a mean daily dose of just under 30mg.

13.5.1.2 Dispensing
Across all drugs prescribed, there is a higher proportion of weekly take-home dispensing in stark contrast to practice in other countries.

Regionally, among oral methadone prescriptions, there is wide variation in dispensing arrangements. Around two-thirds of all dispensing in the North East, South West and East Midlands was for daily pickup. Single weekly pickups were the most popular dispensing arrangement for GPs in London, the West Midlands, East Anglia, and the North West regions. GPs from the South East region were almost equally prescribing daily and weekly pickups (47.3 per cent and 42.9 per cent respectively) as were GPs from Yorkshire and Humber (48.5 per cent and 41.4 per cent respectively) and for both regions, the proportion of GPs prescribing daily dispensing is slightly higher.

Shared care
Less than half of all methadone tablets were prescribed within shared care and only one-quarter of all dihydrocodeine prescriptions involved shared care.

Regionally, there is wide variation in prescribing within shared care; while for five regions (East Anglia, East Midlands, London, North East and North West) around 60 per cent of all prescribing used shared care, and for a further three (South East, South West and West Midlands) over 70 per cent of prescribing was within shared care, less than one-third (30 per cent) of all prescribing in Yorkshire and Humber used a shared care arrangement.

13.6 Conclusions and recommendations
There was much activity among GPs in relation to both seeing opiate misusers (half of the sample) and prescribing (half of those who attended an opiate misuser). However, against this encouraging backdrop, there are serious concerns. There was, in 2001, a widespread lack of confidence among GPs to provide services to opiate misusers, huge geographical variability in the type of prescribing, level of shared care involvement and low-dose dispensing, and widespread extensive reliance on weekly take-home prescriptions.

The authors recommend a further national survey of GPs’ attitudes towards, and management and treatment of, opiate misusers to compare with the data obtained in 2001, so as to identify healthy changes that have been achieved and identify areas of necessary further attention.
14 References


Appendix 1: The questionnaire

GP QUESTIONNAIRE – DETECTION AND TREATMENT OF ILLICIT OPIATE MISUSE
For the purpose of this survey, we would like to know about patients who are misusing heroin and/or other illicitly obtained opioids AND those who are in treatment.

About you and the practice in which you work:
1. Gender: Male [ ] Female [ ] Age: [ ]
2. Years qualified as doctor: [ ] Years working as GP: [ ]
   Do you work at the practice: full time [ ] part time [ ]?
   In a typical week, how many hours do you work at the practice? [ ]
3. Number of full-time equivalent GPs in the practice (including yourself): [ ]
4. Number of patients in the practice: [ ]
5. How would you describe the location of your practice? Urban [ ] Suburb [ ] Rural [ ] Other [ ] (please state) ………………………………………………

When answering questions 6 - 10, please include all patients you have had consultations with, regardless of whether they are on your personal list, are new or temporary patients.
6. In the last 4 weeks how many different patients did you see for problems associated with misuse of heroin or other opioid drugs (or in treatment for such a problem)?

7. How many of these patients were: Male: [ ] Female: [ ]
8. How many of these patients were aged: under16 [ ] 16-24 [ ] 25-40 [ ] over 40 [ ]
9. How many of these were new attenders (to you) for this problem? [ ]
10. Did you prescribe substitute opiate drugs (eg methadone or buprenorphine) for any of the patients reported in question 6?
   Yes [ ] No [ ]
   If yes, please specify the number of patients [ ] and please provide details in the grid below (if you have seen more than 4 patients, please continue on a separate sheet).

<table>
<thead>
<tr>
<th>Patient</th>
<th>NHS or Private (eg methadone or buprenorphine)</th>
<th>Drug(s) prescribed (eg syrup, tablet, ampoule)</th>
<th>Form(s) of drug (eg syrup, tablet, ampoule)</th>
<th>Daily dose (mg)</th>
<th>No. of pick-ups per week (eg weekly collection = 1)</th>
<th>Shared care arrangement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
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<td>Yes / No</td>
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<td>B</td>
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<td>Yes / No</td>
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<td>C</td>
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<td>Yes / No</td>
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<tr>
<td>D</td>
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<td>Yes / No</td>
</tr>
</tbody>
</table>

11. If "None" please indicate reason(s): Tick one or more
   - None of my opiate misusing patients attended during this period [ ]
   - No opiate misusers currently registered at the practice [ ]
   - Opiate misusers are seen by other GP(s) in the practice [ ]
   - I am not willing to treat opiate misusers [ ]
   - Other (please state) ……………………………………………… [ ]

Continue on to Q12.
12. Which of the following applies to your practice?  

<table>
<thead>
<tr>
<th>KNOW</th>
<th>YES</th>
<th>NO</th>
<th>DO NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• There is a policy for the management of opiate misusers in a formal shared care arrangement with specialist service</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Care of opiate misusers is not part of the work of our practice</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• There is a limit on the number of opiate misusers who are patients at the practice</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• There is a limit on the hours during which opiate misusers can be seen by a doctor</td>
<td>[ ]</td>
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</tbody>
</table>

Please read the following definitions before answering questions 13 & 14

- “Specialised generalist”/“intermediate practitioner” - a practitioner whose work is not primarily concerned with drug misuse treatment, but who has developed a special interest in treating drug misusers. Such practitioners would have expertise and competence to provide assessment of most cases with complex needs.

- “Generalist” - medical practitioners for whom the treatment of drug misuse is not a specialist area of their work.

13. Do you consider yourself to be a “generalist” [ ] “specialised generalist” [ ] in this field?

14. Are any of the other doctors in your practice a “specialised generalist” in this field?  
Yes [ ] No [ ]

15. Is extra remuneration provided locally for prescribing methadone for illicit opiate misuse?  
Yes [ ] No [ ]

16. Have you heard of the primary care network - Substance Misuse Management in General Practice [SMMGP]?
Yes [ ] No [ ]

17. Do you receive a copy of the SMMGP newsletter?  
Yes [ ] No [ ]

18. For the following specialist services, please rate them in terms of their services/support to GPs locally (tick one box for each item)

<table>
<thead>
<tr>
<th>Service</th>
<th>Very Good</th>
<th>Good</th>
<th>Satisfactory</th>
<th>Poor</th>
<th>Very poor</th>
<th>Service does not exist locally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community drug team</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Drug dependency unit</td>
<td>[ ]</td>
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<tr>
<td>Specialist in-patient opiate detox</td>
<td>[ ]</td>
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<tr>
<td>Dual diagnosis clinic</td>
<td>[ ]</td>
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<tr>
<td>Residential rehabilitation for drug misuse</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Drug counselling services</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>Social services substance misuse teams</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
</tbody>
</table>
19. Please indicate your views on the following areas of practice in the management of illicit opiate misuse by ticking an appropriate box from each of the three sections below:

<table>
<thead>
<tr>
<th>Potential areas of practice</th>
<th>How appropriate is this activity for you as a GP?</th>
<th>How confident are you that you can perform these activities safely and competently without specialist support?</th>
<th>Please indicate your current practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very</td>
<td>Somewhat</td>
<td>Not at all</td>
</tr>
<tr>
<td>Provide general medical services to opiate misusers</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Assess opiate users for dependence</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Confirm drug use with urine screen</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Dose assessment prior to substitute (e.g. methadone) prescribing</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Prescribe methadone for maintenance</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Prescribe methadone for reduction</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Prescribe methadone to be consumed under supervision (e.g. at a pharmacy)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Prescribe injectable methadone for maintenance</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Prescribe buprenorphine for maintenance</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Prescribe buprenorphine for reduction</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>Prescribe lofexidine for detoxification</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Offer screening for HIV, hepatitis B &amp; C</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>Vaccinate injecting drug users for hepatitis B</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>Conduct drug-related counselling</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
20. Please indicate your opinion on the following statements by ticking the box that most closely represents your views:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would be willing to provide general medical services for patients who consult me about opiate misuse.</td>
<td></td>
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</tr>
<tr>
<td>Any GP in this locality who is willing to treat opiate misusers is likely to find himself/herself overwhelmed by these patients.</td>
<td></td>
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<tr>
<td>I feel confident in my ability to work with opiate misusers.</td>
<td></td>
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<tr>
<td>The recent Department of Health Clinical guidelines provide me with the basis for a more confident role in the treatment of opiate misusers.</td>
<td></td>
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<tr>
<td>The demands on a GP’s time which opiate misusers are likely to make are not manageable within the routine schedule of the surgery.</td>
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<tr>
<td>Opiate misusers require forms of therapy beyond the competence of the ordinary GP.</td>
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<tr>
<td>Opiate misusers are rewarding patients to treat.</td>
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<tr>
<td>The most important aim of treatment is to help opiate misusers become drug free.</td>
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<tr>
<td>Opiate misusers pose a threat of aggression or violence in GP surgeries.</td>
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<tr>
<td>I would remove a patient from my list if I knew that they were an opiate misuser.</td>
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<tr>
<td>I have easy access to specialist support when working with opiate misusers.</td>
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<tr>
<td>I am willing to work with more opiate misusers if I have access to specialist support.</td>
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</tr>
<tr>
<td>GPs should have access to specialist support on-site at the practice in order to work effectively with opiate misusers.</td>
<td></td>
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<tr>
<td>GPs should receive an enhanced capitation fee for prescribing methadone to opiate misusers</td>
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<tr>
<td>I am willing to prescribe methadone to opiate addicts, if prior assessment of dose requirement has been undertaken by specialists.</td>
<td></td>
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<tr>
<td>The current level of remuneration for a GP’s work with drug misusers is adequate.</td>
<td></td>
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<tr>
<td>Lack of ready access to specialist input would deter me from treating opiate misusers.</td>
<td></td>
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</tr>
<tr>
<td>I am unwilling to increase the number of opiate misusers I care for under any circumstances.</td>
<td></td>
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<tr>
<td>Opiate misusers should be managed by specialist drug agencies and not by GPs.</td>
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<tr>
<td>There are satisfactory levels of specialist support for opiate misusers in my area.</td>
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</tbody>
</table>

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY. PLEASE RETURN IT TO US IN THE “FREEPOST” ENVELOPE PROVIDED (NO STAMP REQUIRED) AND YOU WILL RECEIVE A £10 GIFT VOUCHER.