OFFICE-BASED METHADONE PRESCRIBING: ACCEPTANCE BY INNER-CITY PRACTITIONERS IN NEW YORK

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ABSTRACT In the US, methadone maintenance is restricted by federal and state regulations to large specialized clinics that serve fewer than 20% of the heroin-dependent population. In Europe, Canada, and Australia, primary health care providers already are utilized widely as methadone prescribers. In preparation for a limited study of office-based methadone treatment in New York City, 71 providers from 11 sites were surveyed about their willingness to prescribe methadone in their office-based practices. Of the 71, 85% had methadone-maintained patients who came to their practice for other care. One-third felt knowledgeable enough to prescribe methadone, and 66% said they would if given proper training and support (88% among AIDS care providers). Half expressed concern that they might be unable to meet the multiple needs of these patients. With additional training and ancillary support, the 47 providers willing to become methadone providers could serve, at 10–20 patients each, 470–940 patients, a population the size of 3–5 average methadone clinics.

INTRODUCTION

There is growing interest in office-based prescribing as a means of expanding and improving methadone maintenance treatment (MMT) in the US. Primary health care providers already are utilized widely as methadone prescribers throughout Europe, Australia, and Canada,[1,2] and in some regions over 50% of methadone is prescribed in the offices of general practitioners and is dispensed in community pharmacies.[2–4]

This approach has provided the chief means of expanding MMT availability

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and has played a key role in containing the acquired immunodeficiency syndrome (AIDS) epidemic among injection drug users in several countries.[5] In the US, however, this form of practice is restricted severely by federal and state regulations confining methadone maintenance to large, specialized clinics,[6–8] which serve fewer than 20% of the heroin-dependent population.[9] To address the problems of treatment availability and quality, the Institute of Medicine of the National Academy of Sciences has called for the integration of methadone maintenance into standard medical practice,[7] a view also supported by the 1997 National Institutes of Health Consensus Development Conference *Effective Medical Treatment of Opiate Addiction*[9] and by the White House Office of National Drug Control Policy.[10]

In 1998, we began a study of office-based prescribing (National Institute on Drug Abuse [NIDA] RO1-DA11324) for a group of 100 patients enrolled in the MMT programs of Montefiore and Beth Israel Medical Centers and the Albert Einstein College of Medicine, which currently treat over 12,000 patients. As part of the process of identifying and recruiting clinicians to participate in the study, we surveyed practitioners within our institute's primary care and infectious disease clinic sites, from which we would draw our prescribers. All of this sample of practitioners were employed by the institution full time and provided continuous and comprehensive care for 1,500–2,000 patients each. While not in private practice, they operated from neighborhood clinics that are typical of the system providing primary care to the city's poorer residents. We assessed prior experience with methadone patients in their medical practices, their attitudes toward MMT, and their willingness to prescribe methadone within office-based practices.

METHODS

A 21-item survey was administered to primary care and human immunodeficiency virus (HIV)/AIDS providers (physicians, physician assistants, and nurse practitioners) in 11 practice sites of Montefiore, Beth Israel, and St. Joseph's Medical Centers in New York City and Yonkers. The survey was conducted at each practice site, with the questionnaire filled in by the interviewer, J. McNeely. Those providers who were unable to schedule an interview were asked to fill out the survey themselves and mail it, with telephone follow-up by the same interviewer; no differences were found in the two methods of responding.

SAMPLE

All respondents (physicians, physician assistants, and nurse practioners) worked in community-based primary care and HIV/AIDS clinics serving inner-city popu-

TABLE I Sites and Practitioners Surveyed

Site	No. Attempts	No. Responses	Response Rate
Community health centers	73	55	Range 44–100%
Infectious disease (HIV/AIDS) clinics	26	16	Range 47–82%
Total	99	71	72%

	Practitioners Surveyed	
	n	% of Sample
Professional specialty		
Family medicine	37	52
Internal medicine	13	18
Infectious disease	10	14
Obstetrics/gynecology	2	3
Family nurse practitioner	4	6
Physician assistant	5	7
Practice settings of respondents		
Community health centers	55	77.5
Infectious disease clinics (HIV specialty)	16	22.5
Years postresidency		
Mean (SD)	10.2 (6.5)	
Range	1–24	

lations of the Bronx and Manhattan: 60–65% of patients receive Medicaid at the community health centers (Paul Meissner, personal communication, Montefiore Medical Center, April 21, 1999), up to 77% at the HIV/AIDS clinics (Paul Meissner, oral communication, April 21, 1999; Millie Gonzalez-Haig, personal communication, Beth Israel Medical Center, April 21, 1999). Respondents were principally in family medicine, internal medicine, and infectious disease and had been practicing an average of 10.2 years (see Table I). Of a total of 99 clinicians employed at the 11 sites, 71 (72%) agreed to participate in the survey.

RESULTS

Prior Experience with Methadone Patients

Most of these clinicians had extensive prior experience providing medical care for methadone patients: 85% currently had MMT patients in their practices, with a median of four patients in their care at the time of the study (see Table II).

Providers in practices that treated HIV/AIDS were most experienced with methadone patients, as expected given the co-occurrence of HIV and heroin use in New York City. They reported a median of 40 MMT patients in their practices

TABLE II Prior Medical Experience with Methadone Patients

Item	All Providers, N = 71	Primary Care, N = 55	HIV/AIDS, N = 16
Have ever had MMT patients in their care	70 (99%)	54 (98%)	16 (100%)
Number of MMT patients ever (median)	25	13	100
Currently have MMT patients in their care	85%	83%	92%
Number of MMT patients currently in their care (median)	4	3	40

and had seen a median of 100 in their careers. Respondents said that they had also seen many more methadone patients—typically hospital inpatients—in the course of their clinical training. Five (5) practitioners volunteered that they had also worked in methadone treatment programs at some point in their careers, both as consultant medical providers and, in one case, as medical director of an MMT program.

Attitudes and Knowledge Regarding Addiction and Methadone Maintenance Treatment

The majority (70%) of providers reported that they were "comfortable" managing the care of drug users in primary care (see Table III), and 72% were convinced of methadone's effectiveness, supporting methadone "treatment on demand."

TABLE III Knowledge and Attitudes Regarding Methadone Maintenance Treatment

Item	All Providers, (N = 71)	Primary Care, (N = 55)	HIV/AIDS, (N = 16)
Comfortable managing the care of drug users*	49 (70%)	34 (63%)	15 (94%)
Convinced of effectiveness of methadone*	50 (72%)	38 (72%)	12 (75%)
Support access to MMT for all addicts*	51 (72%)	38 (69%)	13 (81%)
Methadone should be withdrawn when heroin use ceases*	22 (32%)	17 (32%)	5 (31%)
Abstinence (including from methadone) is the principal goal of MMT*	26 (37%)	22 (40%)	4 (25%)
No time limits should be set on MMT*	37 (52%)	28 (51%)	9 (56%)
Average level of knowledge on scale of 1–10 (self-assessed)	5.5	5.1	6.5
Know enough to prescribe methadone now (self-assessed)	25 (35%)	16 (29%)	9 (56%)
Concerned about inability to meet the multiple needs of these patients*	35 (50%)	33 (61%)	2 (13%)
Would prescribe methadone, given proper training and support	47 (66%)	33 (60%)	14 (88%)

*Assessed on 5-point scale, positive responses combined. Items developed and used previously with methadone program staff by J. R. Caplehorn et al.

However, specific attitudes about the goals and length of methadone treatment varied substantially among this group, regarding, for example, whether limits should be set on its duration, if methadone should be withdrawn after the cessation of illegal drug use, and whether abstinence from all opioids, including methadone, should be the principal goal of treatment. These responses reveal some serious reservations on the part of many practitioners about the philosophy of indefinite maintenance treatment and suggest the need to address these issues in the training of prospective prescribers. Still, 52% supported setting no limit on the duration of maintenance treatment.

When asked to assess their knowledge about methadone pharmacology and clinical application (on a scale of 1 to 10), the average score was 5.5. Most cited their clinical training as the primary source for what they did know about methadone, but very few reported learning about MMT within a structured curriculum in medical school or during residency training. Still, 35% felt knowledgeable enough to prescribe methadone.

Willingness to Prescribe Methadone Within Their Practices

Of all practitioners surveyed, 66% said that, given proper training and support, they would prescribe methadone for their patients. However, there is concern that the "multiple needs" of methadone patients may be difficult to meet in these medical practice settings. Half (50%) of the providers shared this concern. In interviews, many practitioners saw the methadone patient population as having more complicated psychosocial needs and medical deficits than their average patient and called for additional supports.

Perhaps because they already saw the care of drug users as a substantial piece of their work, the HIV/AIDS providers in this sample were most enthusiastic about prescribing methadone: 88% of them were ready to prescribe. They felt somewhat more knowledgeable about MMT than most primary care providers—94% of the HIV/AIDS practitioners (versus 63% of the primary care practitioners) were comfortable working with drug users, and they were less concerned that they would be unable to meet the multiple needs of methadone patients.

CONCLUSIONS

For the practitioners we surveyed, the question of prescribing methadone was not laden with fear about bringing drug users into their practices—indeed most already had, and continue to have, substantial experience with methadone patients. Rather, methadone was seen as another useful tool for better managing the overall health of patients who are addicted.

However, there was concern among these practitioners about the substantial medical and psychosocial needs that such patients bring. Combined with acute awareness of the limited time available (under the current productivity pressures of outpatient medical practice and managed care) and the lack of adequate support staff (e.g., social workers, counselors, and case managers), this concern is realistic. HIV/AIDS providers generally felt less worried about the extra needs of methadone patients, perhaps because of the more extensive ancillary support in these practices. If methadone is to be prescribed in the context of primary care medicine in this country, we should make efforts to provide such additional support, both for the benefit of the patient and for the ability of the practitioners to maximize the effects of methadone prescribing. This objective need not be an impediment to instituting office-based care of heroin addicts. The "shared care" system of general practice in the United Kingdom, in which addiction specialists and supplemental counseling and social services support a network of primary care physicians caring for methadone patients, may offer a suitable model.[11]

Some recent work in the US suggests that a significant number of primary care providers are prepared to accommodate methadone prescribing within their practices. The medical maintenance model[12]—employed for the most well-stabilized and socially integrated patients—is now developing in Connecticut, Washington, and California following 10 years of positive experience in New York. Over the past year as part of our NIDA research study, we have initiated methadone prescribing within primary care at our institutions, in which 15 primary care providers have assumed prescribing authority for 70 methadone patients currently enrolled in our MMT programs.

The principal finding of this study is that a significant proportion of these practitioners already were caring for the populations and communities most in need of more addiction treatment and were supportive of the current initiatives to extend methadone treatment to mainstream medical practice. Even at the caseload of our current study (3–5 patients per practitioner), the 47 respondents of this sample willing to prescribe methadone in their practices could accommodate 200 patients—the equivalent of a standard methadone clinic. At 10–20 patients each, they could care for 470–940—the equivalent of many large methadone programs. With additional training and proper ancillary support, it appears that a large potential workforce of medical providers is available and accepting of office-based prescribing within primary care and HIV/AIDS practices. Based on the growing body of evidence from abroad and our experience thus far in New York City, methadone prescribing can be integrated successfully into medical practice.

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