IOTOD

improving outcomes in the
treatment of opioid dependence

IMPROVING OUTCOMES IN THE TREATMENT OF OPIOID DEPENDENCE (IOTOD) INSIGHTS REPORT

Results from a European Healthcare practitioner survey surrounding perspectives and practices Around opioid-dependence treatment with long-acting buprenorphine

2021 INSIGHTS REPORT

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Executive summary

Opioid addiction is a chronic and relapsing condition causing personal, social, and economic harm. Daily methadone and buprenorphine are traditional and widely used treatment approaches. Long-acting buprenorphine (LAB) formulations are becoming increasingly available although information regarding use is scarce in non-clinical settings. This report highlights the responses of healthcare professionals (HCPs) from different specialist areas (associated with opioid dependence treatment) and their current perspective and practice surrounding the use of LAB.

Most respondents to the survey were primary care specialists rather than secondary care specialists and the countries they practiced in were very UK-weighted. Surprisingly, many primary care specialists preferred LAB formulations although were low prescribers of LAB, whereas the secondary care specialists preferred daily dose formulations but were higher prescribers of LAB.

Access to LAB, and the associated costs, were perceived barriers to increased LAB implementation, however, many respondents indicated a lack of information regarding LAB suggesting that activities and educational promotions raising awareness targeting this may alleviate concerns and increase prescriptions. The attitudes and practices towards using LAB varied greatly amongst healthcare practitioners that participated in this survey.

It is important to note that the proportion of respondents offering different alternatives to face-to-face appointments is high. More emphasis and education regarding the importance of strong patient support networks (both within the clinic, such as social work, and outside the clinic, such as peer support) for both patient and prescriber may result in greater benefits to patients and better retention. Further education regarding transferring patients from methadone to LAB and improving patient profiling (to ensure the appropriate set-up for support is in place) may also facilitate use and retention.

Following expansion of treatment services via telemedicine and non-medical prescribers, greater education surrounding the advantages and disadvantages of LAB formulations – both patient-focussed and practitioner-focussed – and their place in the arsenal of treatment options is warranted. Further insight into the reasons behind the low rates of LAB prescribing by primary care specialists despite higher reporting of LAB as a preferred mode of administration would be interesting. Likewise, further insight could be gathered among secondary care specialists to determine the disconnect between their stated preferred mode of administration and what is occurring in practise.

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Introduction

Opioid addiction is a chronic and relapsing condition causing personal, social, and economic harm,[1] with opioid substitution therapy the established first-line treatment.[2,3] Methadone and buprenorphine are often considered the gold standards for opioid substitution therapy;[4,5] while more recently, long-acting buprenorphine formulations have been tested in clinical trials[6] and have become increasingly available, however, there is currently a lack of real-world data. However, information is scarce surrounding the use of long-acting buprenorphine formulations in non-clinical settings.

This survey report highlights the responses of healthcare professionals (HCPs) from different specialist areas and their current perspective and practice to questions surrounding the use of long-acting buprenorphine (LAB). The survey featured 36 questions and responses from 500 HCPs across 18 different countries.

Results

Survey participant occupation

The job titles were spilt into Addiction Specialist (7.0%), Psychiatrist (3.6%), GP/primary care physician/family doctor (56%; hereafter referred to as PCP), Nurse (14.0%), Pharmacist (4.8%), and other (4.65%). Other titles included Health Visitor, Hospital Specialist, and Consultant Haematologist. The country distribution was UK-heavy, with 79.2% of respondents practising in the UK and 20.1% of respondents practising in the rest of the world (Figure 1).

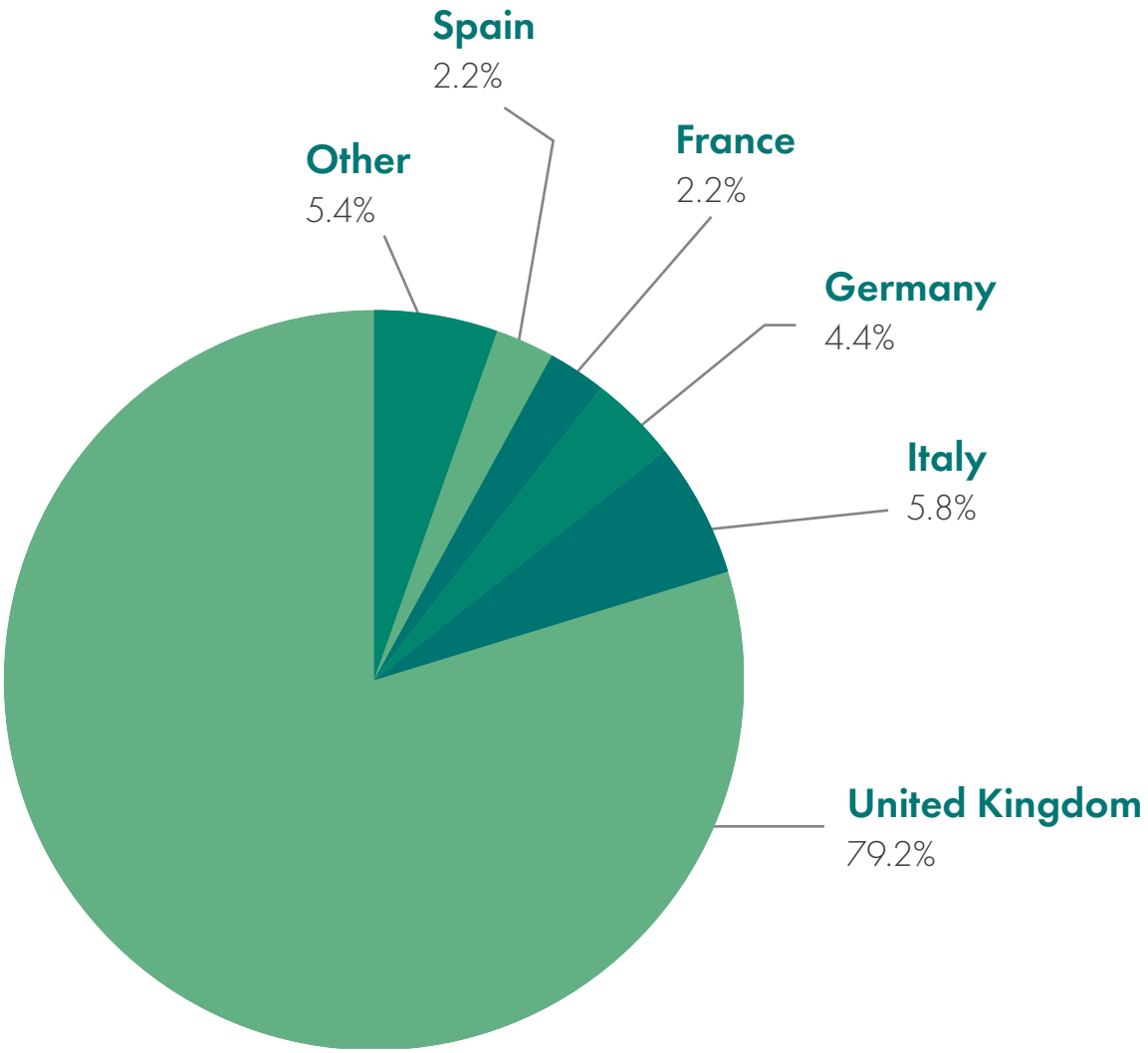


Figure 1. Country distribution of survey respondents.

HCP prescription habits

Q. What is your preferred mode of buprenorphine administration?

Primary care specialists (PCPs, nurses, and pharmacists) are more willing to use injectables/implants and transdermal patch as a mode of application (Figure 2). Secondary care specialists (addiction specialists and psychiatrists) seem to prefer buccal film and sublingual tablets more than the longer-acting formulations (Figure 2). This may be due to the difference in the patient type managed by each profession. Primary care professions may treat less complex or problematic cases (or those they perceive as such) or use LAB to treat pain issues. Secondary care specialists may manage a more complex patient who requires more frequent medical interventions or contact. It could also reflect a preference for 'traditional' daily medications that might relate to knowledge and confidence surrounding use and efficacy versus 'newer' formulations.

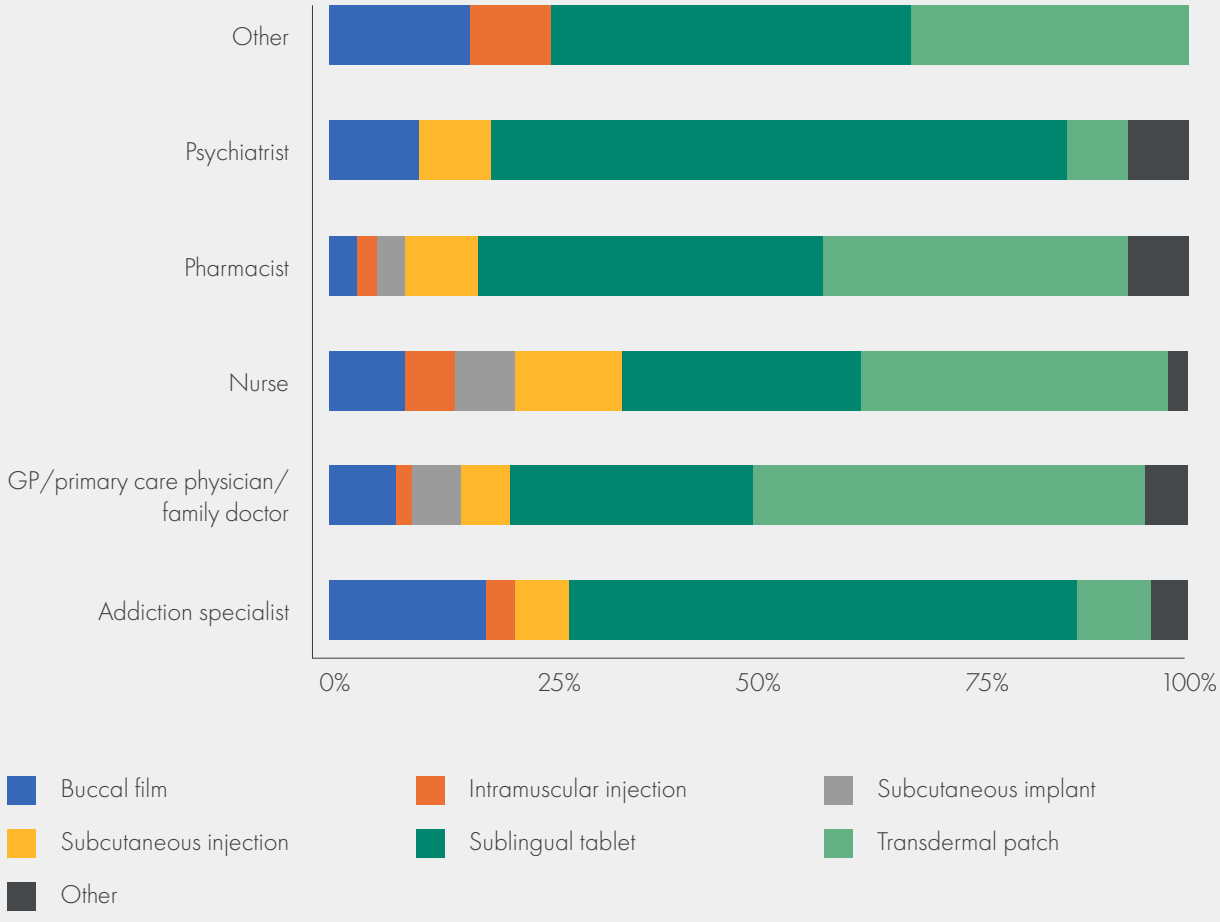


Figure 2. Proportion of preferred mode of action of buprenorphine for each profession.

Q. To what proportion of your patients do you prescribe long-acting buprenorphine (LAB)?

Approximately 55–75% of respondents from each profession report that they prescribe LAB to 0–10% of their patients (Figure 3), with 80–90% prescribing LAB to less than 30% of their patients. The respondents who had the highest percentage of LAB prescriptions were addiction specialists, psychiatrists, and nurses, whereas PCPs and pharmacists were the lowest prescribers of LAB formulations.

It is interesting to note that secondary care specialists prefer daily dose formulations (Figure 2) but prescribe more LAB. Whereas PCPs prefer LAB formulations but prescribe it least. In general, LAB prescription was low. This could relate to access and availability, or low awareness, general knowledge and confidence surrounding use of newer formulations and how to adopt into practice settings and use with different patient profiles.

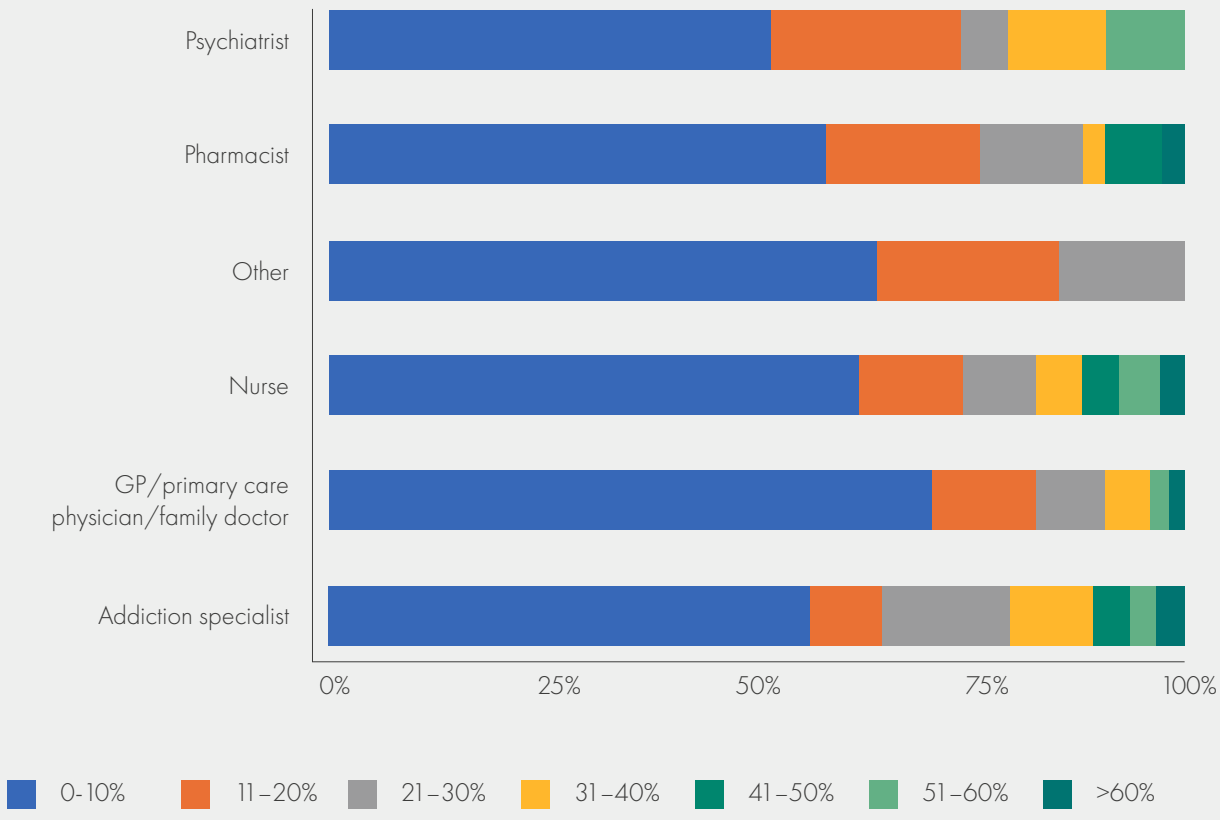


Figure 3. Proportion of patients prescribed long-acting buprenorphine for each profession.

Q. If you do not prescribe long-acting buprenorphine (LAB) in your practice, please share the main reason(s) why?

In general, all professions had concerns about bureaucracy and whether they had access to LAB (Figure 4). Addiction specialists reported more concerns relating to storage/handling of LAB or patient/prescriber preference for a different buprenorphine formulation and fewer concerns around administration or requiring more information about LAB itself. Psychiatrists reported more concerns for different buprenorphine (or other OST) formulations and a requirement for further information on LAB. Awareness raising activities targeting this group may alleviate concerns relating to LAB. PCPs were similarly concerned in all areas, whereas nurses were concerned about staffing for administration, and both nurses and pharmacists were influenced by patient/prescriber preference.

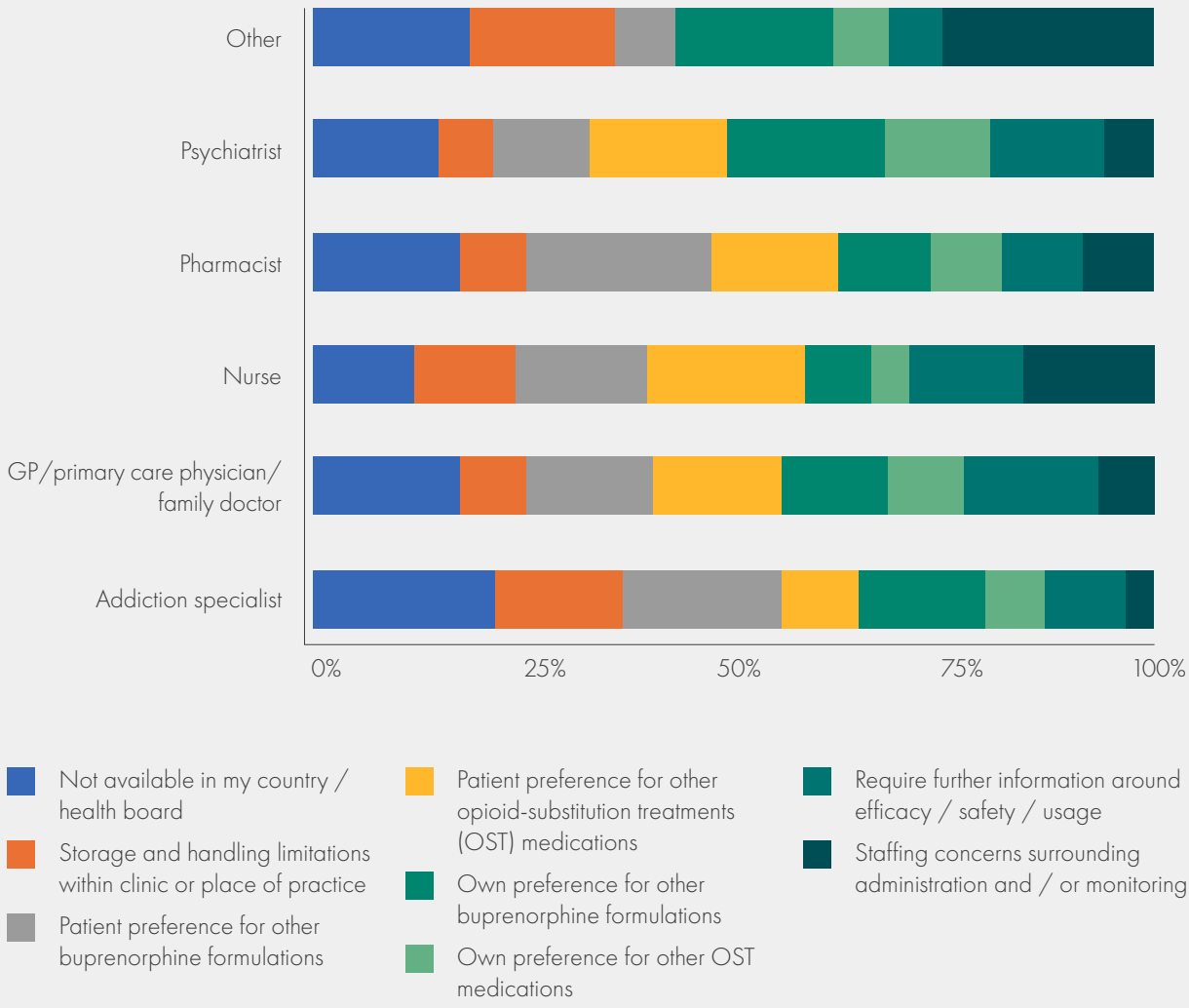


Figure 4. Range of reasons for not prescribing long-acting buprenorphine for each profession.

Q. When did you start prescribing long-acting buprenorphine (LAB) to patients?

All job groups reported prescribing LAB prior to the 2020 pandemic to varying degrees, with PCPs the most frequent pre-pandemic (2019) prescribers at 72.0%. Interestingly, only 14% of addiction specialists were prescribing LAB prior to the pandemic, although prescription of LAB has increased to 69% since in our respondents. Fifty-six percent of nurses report that they have not yet started using LAB formulations, which is in contradiction to the preferred mode of application question (Figure 2) where approx. 55% of respondents preferred LAB. This possibly suggests that nurses would prefer to prescribe LAB but are currently unable to for some reasons unidentified here.

Q. If you have increased your prescribing of long-acting buprenorphine (LAB) since 2019, please share the main reason(s) why?

Most respondents cite that increased access to LAB, patient preference for LAB and patient lifestyle are factors for increased prescribing (Figure 5). The reduced risk of diversion is also considered a reason for increased prescribing of LAB.

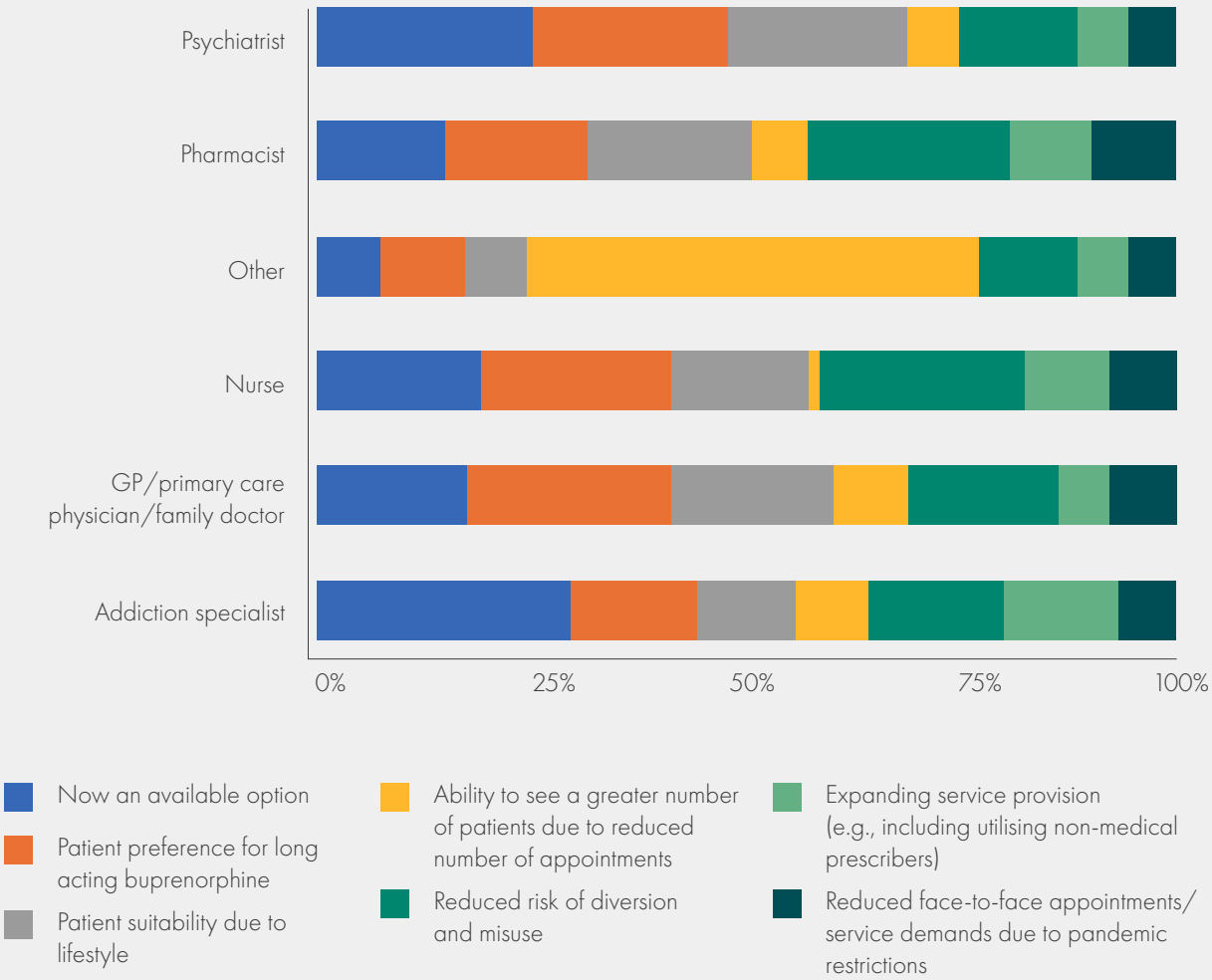


Figure 5. Range of reasons for increasing the prescriptions of long-acting buprenorphine for each profession.

Q. What have been your main sources for education on training surrounding the use of long-acting buprenorphine for opioid-dependence treatment?

Secondary care specialists were more likely to use scientific conferences, scientific publications, and product websites/industry-led learning resources compared to peer-learning or independent websites, whereas PCPs used a wide range of educational resources and greatly valued peer-learning (Figure 6). Other notable responses for education resources were: IOTOD meetings, colleagues, elderly care consultants, addiction prescribing teams, direct training from companies, own reading, and social media. Variation exists here as some respondents noted that there was no training available to them indicating a continued need for provision. This report is anonymous, but it may be worthwhile to survey practitioners more fully on the availability of information and education to better understand educational needs and targeting, to support closing appropriate knowledge gaps and at the very least, raising awareness for existing educational materials.

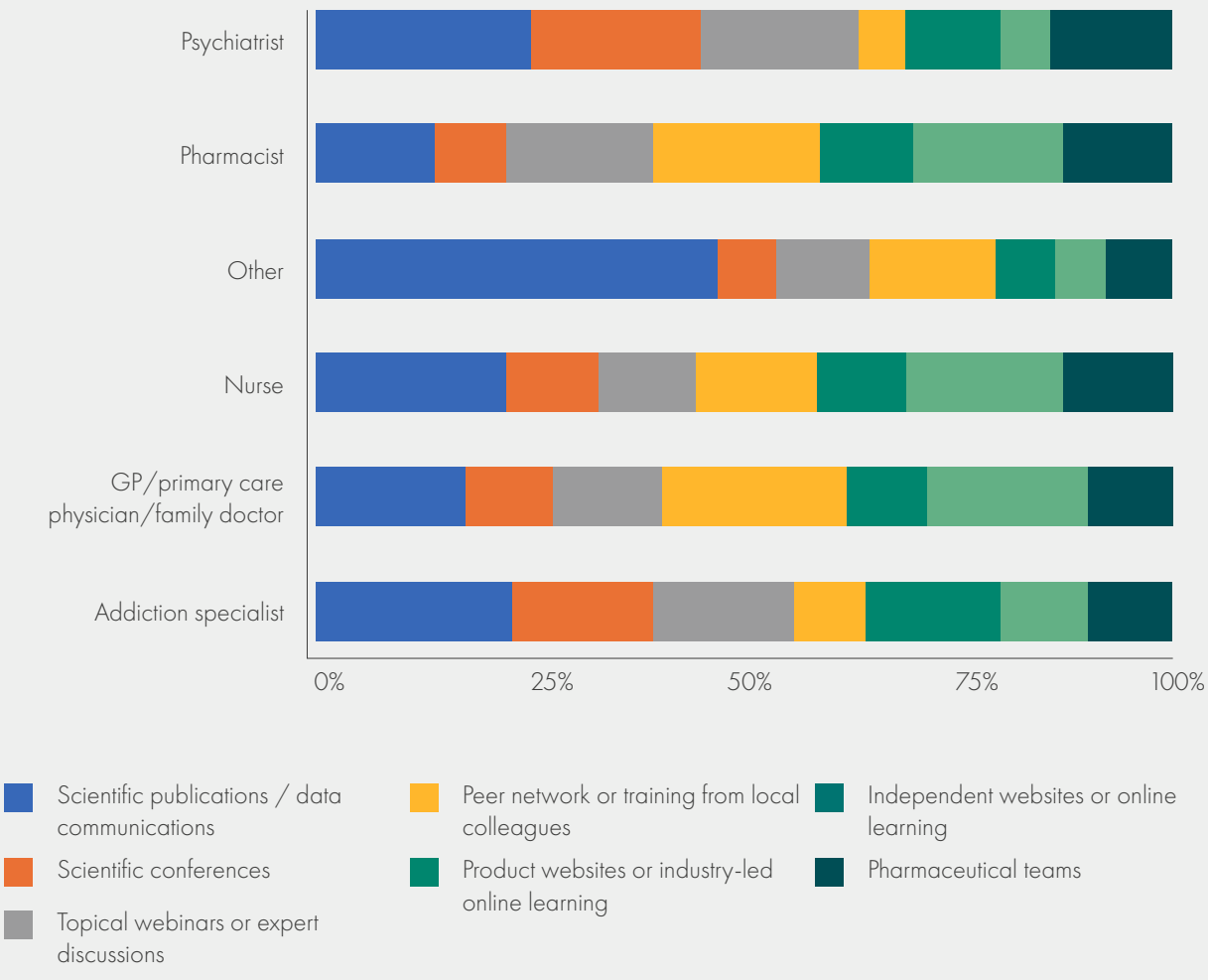


Figure 6. Range of main sources of long-acting buprenorphine information for each profession.

Transitioning to long-acting buprenorphine from other OST

Q. In the last 12 months, what proportion of your patients have you transitioned from methadone, daily buprenorphine, or any other OST to long-acting buprenorphine (LAB)?

Methadone:

Between 60 and 80+% of respondents indicated that they have transitioned 0–10% of patients from methadone to LAB, with only approximately 10–15% of respondents reporting that they have transitioned 11–12% of patients from methadone to LAB.

Daily buprenorphine:

Between 60 and 80% of respondents indicated that they have transitioned 0–10% of patients from daily buprenorphine to LAB, with approximately 10–20% of respondents reporting that they have transitioned 11–12% of patients from daily buprenorphine to LAB.

Other OST:

In general, most respondents transferred few patients from other OSTs onto LAB. Psychiatrists transferred more patients from other OSTs to LAB in comparison to the other job groups. this may relate to secondary care having greater accessibility to LAB than primary care and having greater confidence as a mode of treatment.

Q. What are your main reasons for transferring patients from any other OST onto long-acting buprenorphine?

In general, primary care specialists put great emphasis on duration of symptom control and patient preference compared to the secondary care specialists (Figure 7). Nurses greatly emphasise the ability to spend greater time with patients compared to all other professions whereas PCPs emphasise all aspects apart from the greater ability to see and spend time with patients.

For the secondary care specialists, addiction specialists seem concerned about patient retention in OST, the patient preference for LAB and clear-headedness, lifestyle suitability, and duration of symptom control rather than the risk of diversion or the ability to spend more time with patients (Figure 7). While psychiatrists emphasise the ability to see more patients and expanding service provision (Figure 7).

It would appear the educational needs of secondary care specialists are not uniform and so could be important to target different resources to address specific gaps in knowledge.

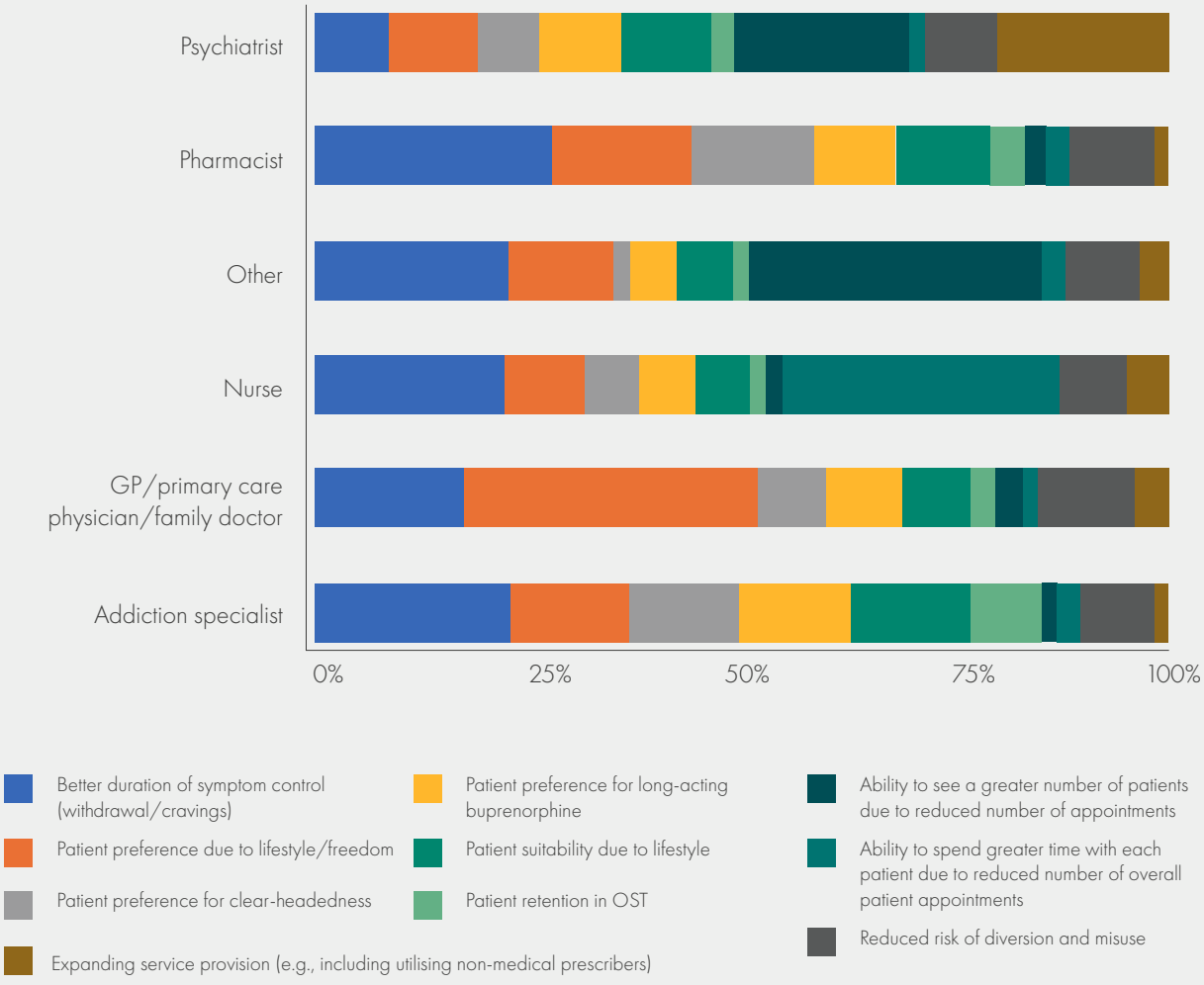


Figure 7. Range of reasons for transferring patients from and other OST to long-acting buprenorphine for each profession.

Q. What are your main reasons for transferring patients from methadone onto long-acting buprenorphine?

Within the primary care specialists, nurses put emphasis on the ability to spend more time with patients as a reason for prescribing LAB but may be less aware of the potential advantages that LAB has to offer patients in terms of duration of symptom control and any associated freedom of movement. PCP responses varied greatly, although most respondents placed lower emphasis on the ability to spend greater time with patients (Figure 8).

Secondary care specialists seemed more concerned about patient retention in OST, the patient preference for LAB, and lifestyle suitability compared with the ability that LAB gives to see more patients and spend more time with each patient (Figure 8). It appears that secondary care specialists may focus on the potential advantages that LAB may offer patients and be less aware of the improved efficiency LAB may offer to their practice (or it is unimportant to them).

Other reasons indicated for transferring to LAB were challenges in pharmacy-based supply in the community for individuals with challenging behaviour, other time commitments, rural locations, and desire to avoid pharmacy congregation, etc.

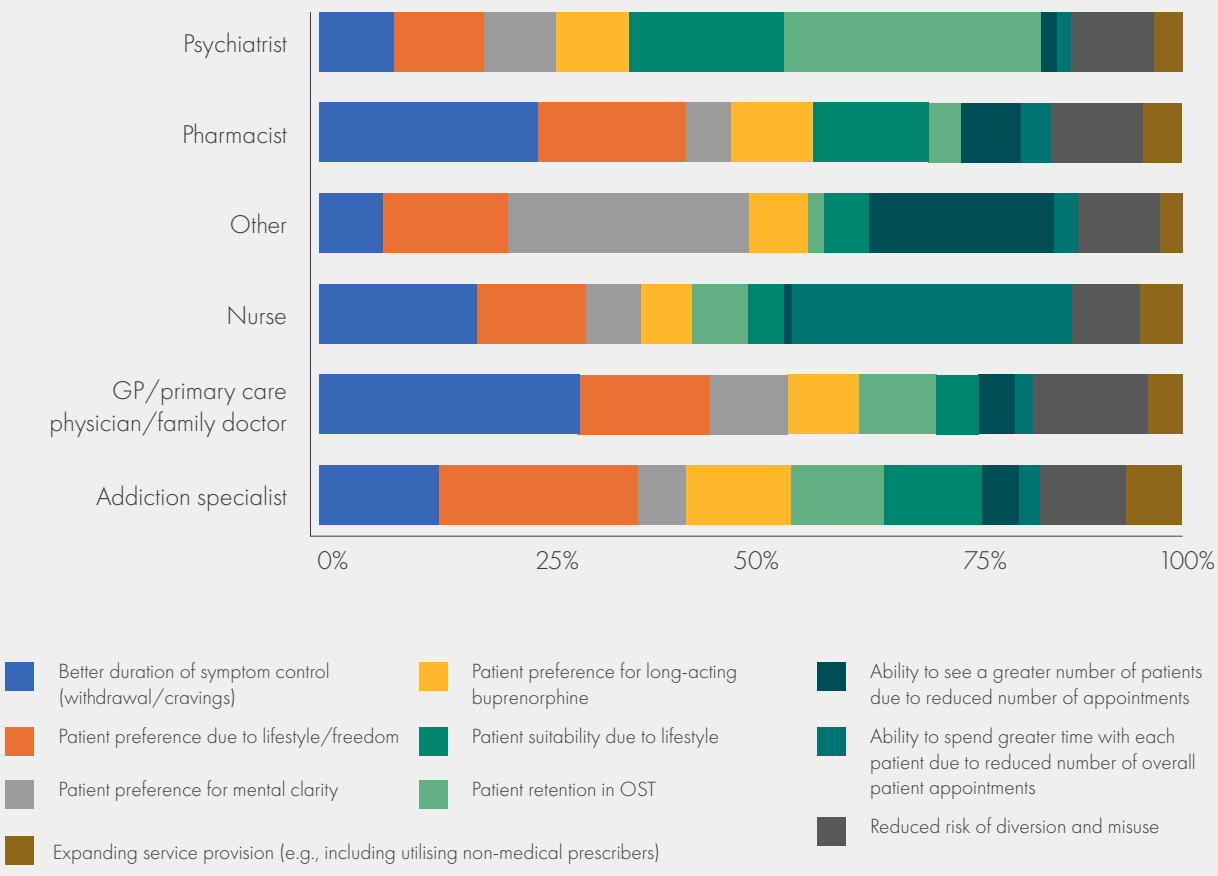


Figure 8. Range of reasons for transferring patients from methadone to long-acting buprenorphine for each profession.

Q. What are your main reasons for transferring patients from daily buprenorphine onto long-acting buprenorphine (LAB)?

In the primary care specialists, PCPs put greater emphasis on duration of symptom control and patient preference compared to the secondary care specialists (Figure 9). Nurses do not place emphasis on the ability to spend greater amounts of time with patients, which is in contrast with their reasons for transferring from methadone to LAB (Figure 8).

In the secondary care specialists, addiction specialists seem concerned about patient retention in OST, the patient preference for LAB, lifestyle suitability, the ability see more patients, and spend more time with each patient than the duration of symptom control (Figure 9). The reasons given for transfer are similar to the reasons given when transferring from methadone to LAB, although with greater emphasis on patient preference and lifestyle suitability and less emphasis on retention. This is surprising as methadone is traditionally associated with better retention rates than buprenorphine,[3] although a recent meta-analysis of oral fixed-dose treatments suggests no difference in retention rates.[7]

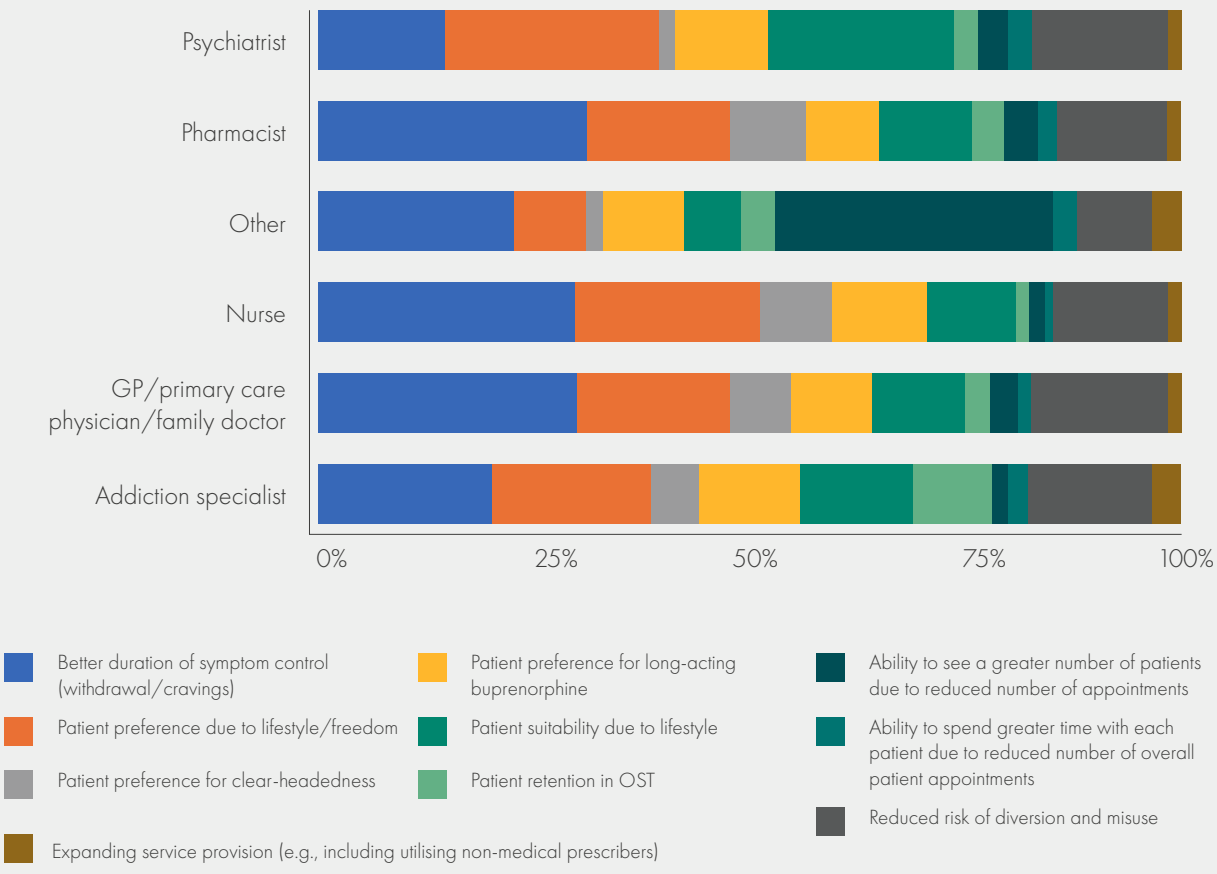


Figure 9. Range of reasons for transferring patients from daily buprenorphine to long-acting buprenorphine for each profession.

Q. Approximately, what proportion of patients do you transfer from methadone to long-acting buprenorphine at the following ranges of Clinical Opiate Withdrawal Scale (COWS) score?

Most respondents report transferring their patients in the lower ranges of the COWS scores (predominantly between 1–12). Interestingly, primary care specialists transfer across a broader COWS range compared with secondary care (especially psychiatrists).

Many primary care specialists report transferring a significant proportion of patients at COWS scores 30–36+. These patients would be classed as in moderately severe to severe withdrawal. Generally, guidelines for buprenorphine induction mention that patients should be in mild to moderate withdrawal, although sometimes starting transferral to buprenorphine until patients are in moderate to severe withdrawal is preferred.[8]

Potentially, more secondary care specialists may be employing the 'Bernese method' where microdoses of buprenorphine are administered which does not precipitate withdrawal.[9] Further education on transfer methods targeting primary care specialists may reduce the number of patients suffering severe withdrawal symptoms during transfer, which may, in turn, encourage patient treatment and aid retention rates.

Q. As a prescriber, how long, on average, does it take you to transition patients from methadone to long-acting buprenorphine?

There is great variability in the lengths of time taken to transfer patients to LAB (Figure 10). For nurses, a large proportion of respondents transfer in less than a day, but they also have many patients who take longer than 10 days to transfer, with a lower number with transfers between. There appears to be no standard practise to transition, although tapering generally seem to be performed over a longer timeframe of 7–10 days.

This variability in transitioning suggests that there could be a need for the creation of optimised transfer educational initiatives, if warranted, by determining whether the variability is associated with transfer failure and not as a result of prescriber preference and practise.

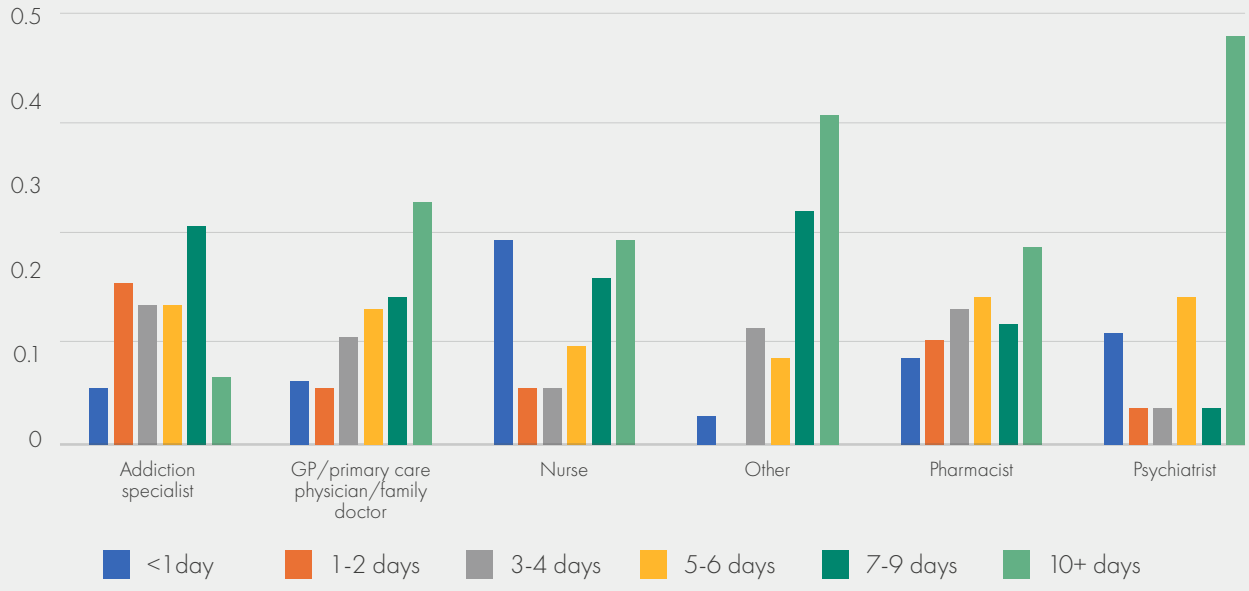


Figure 10. Range of days taken to transfer patients from methadone to long-acting buprenorphine for each profession.

Q. As a prescriber, would you consider transitioning, or do you transition, patients from methadone to long-acting buprenorphine without first tapering from the methadone?

Approximately 60% of respondents from each profession indicated that they would not transition, and not consider transitioning, their patients without tapering the methadone dose. Addiction specialists, psychiatrists, and pharmacists were more likely to transfer, or consider transferring, their patients without tapering when compared with nurses or PCPs.

Transferring to buprenorphine with microdoses of buprenorphine without tapering the methadone dose is often referred to as the 'Bernese method' and is often a quicker method of transfer. As more secondary care specialists are likely to transfer patents using this method, the answers to this question may be an artefact of education surrounding the technique. Further education about this technique, specifically targeting the primary care specialists may facilitate speedier transitions in the future – both for quicker patient stabilisation and a reduction of pressure or demand on healthcare provision and resources.

Discontinuation of long-acting buprenorphine

Q. Complete the sentence: Having a greater control of a treatment plan is ...

In general, over 60% of each profession thought that having control of a treatment plan was important to the majority of their patients (Table 1). It is interesting to note that all psychiatrist indicated that having control of their treatment plan was important to their patients.

Primary care specialists reported that LAB patients experienced greater treatment control than daily methadone or daily buprenorphine. Whereas secondary care specialists indicated that having greater control of their treatment plan was more widely experienced by patients receiving daily buprenorphine compared with either methadone or LAB patients.

The preference that secondary care specialists indicated previously in the report (Figure 2) for daily formulations and similarly the preference for primary care specialists for LAB may be producing an inherent bias in the answers to this question. Taken at face value, the distribution of patient-focussed educational materials to secondary care specialists detailing the potential advantages of LAB formulations may go some way to addressing this potential imbalance; comparatively, there is a wealth of information surrounding daily dosing and methadone or buprenorphine and less information readily available for other OST formulations.

Table 1. Proportion of answers regarding patient control of a treatment plan for each profession.

	Important to the majority of your patients	More widely or commonly experienced by patients receiving daily dose buprenorphine	More widely or commonly experienced by patients receiving long-acting buprenorphine	More widely or commonly experienced by patients receiving daily methadone	More widely or commonly experienced by patients receiving other OST (please specify)	Not important to the majority of your patients
Addiction specialist	48.98%	22.45%	12.24%	4.08%	4.08%	8.16%
GP / primary care physician / family doctor	52.19%	11.75%	20.49%	6.83%	3.55%	5.19%
Nurse	67.12%	4.11%	16.44%	4.11%	0.00%	8.22%
Pharmacist	52.22%	13.33%	20.00%	8.89%	1.11%	4.44%
Psychiatrist	54.17%	16.67%	12.50%	8.33%	8.33%	0.00%

Q. For those patients who could not continue with long-acting buprenorphine (LAB) treatment, what were the reasons for transferring to another OST?

All professions report approximately 45% or more of the time the reasons for discontinuing LAB treatment are either the lack of consistent routine (offered by daily dosing collection) or the reduction in contact with the support network (Figure 11). The inability to tolerate either a single or repeated injection, or the injection being a trigger was important in approximately 30% of responses. Further patient education on the importance of building a strong support network prior to the transition to LAB may be beneficial and increase the transfer rates. Further practitioner education on patient profiling may also be beneficial, so providers can gather a better understanding of either how they can support, or what support may be required, to help improve the chances of transfer success (e.g., building a support network if not already existing).

Other responses given for discontinuing LAB treatment were co-morbid substance use, transdermal patch didn't stay on skin or didn't work/wasn't effective or caused side effects, patient was unable to cope with mental clarity or would not attend appointments regularly.

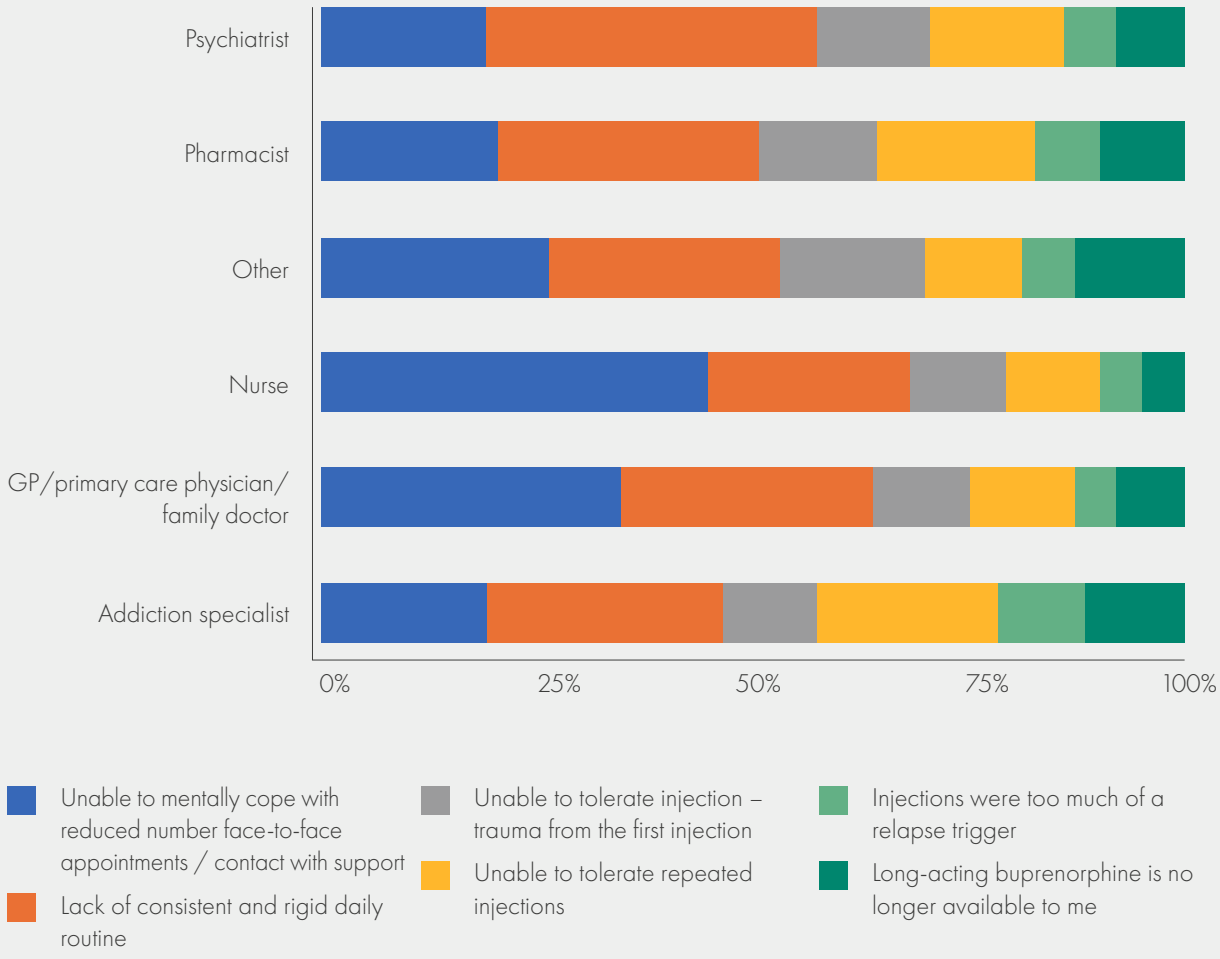
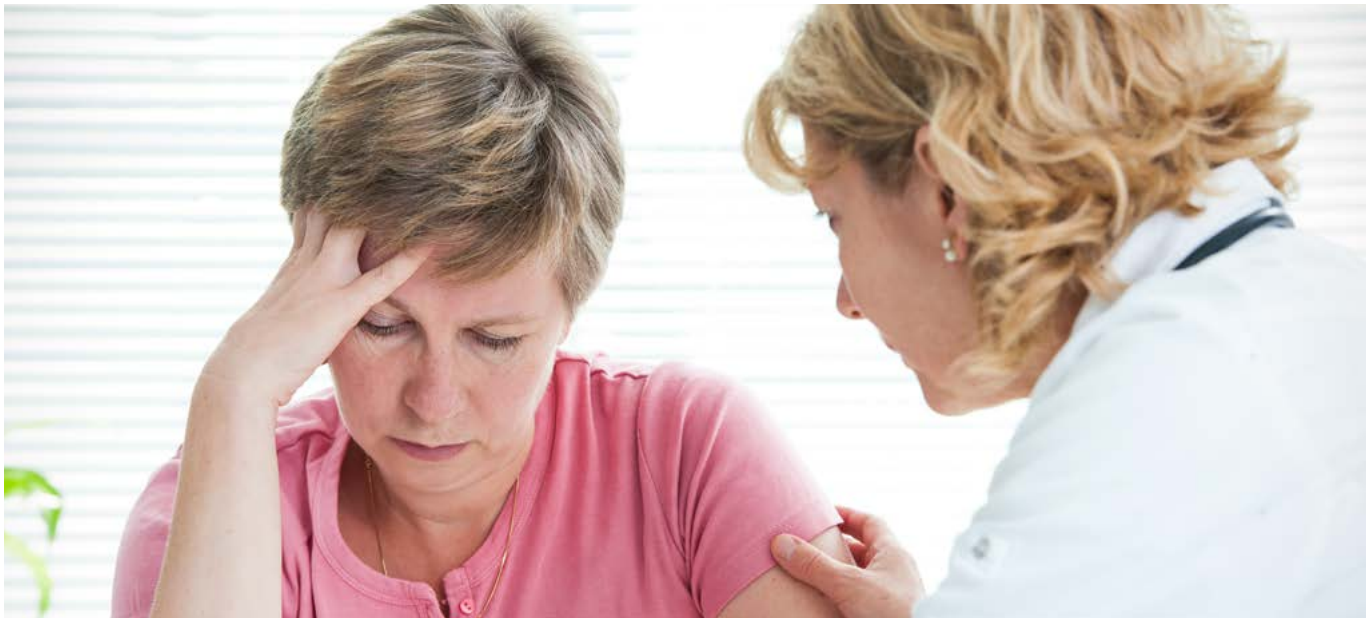


Figure 11. Range of reasons for discontinuing long-acting buprenorphine for some patients for each profession.



Impact of long-acting buprenorphine on patient contact time

Q. How has prescribing long-acting buprenorphine impacted your patient relationships?

Among the primary care specialists, PCPs, nurses, and pharmacists indicated that LAB prescription overall improved relationships (27.0%, 32.0%, and 24.0% of answers, respectively), perceived an increase in trust (14.0%, 16.0%, and 13.0%, respectively), and a reduced dissatisfaction in patient relationships (6.0%, 6.0%, and 5.0%, respectively). The risk of diversion was reduced (11.0%, 7.0%, and 9.0%, respectively), as was stigma (5.0%, 7.0%, and 9.0%, respectively), there was a better duration of symptom control (14.0%, 10.0%, and 11.0%, respectively), and increased lifestyle suitability for the patient (9.0%, 7.0%, and 11.0%, respectively).

Among the secondary care specialists, addiction specialists indicated that LAB prescription overall improved relationships (25.0% of addiction specialist answers) and increased perceived trust within patient relationships (12.0%). They indicated stigma was reduced (0.9%), there was a better duration of symptom control (10.0%), and a reduced risk of diversion and misuse (10.0%). Addiction specialists also indicated a utilisation of non-medical prescribers (6.0%). Psychiatrists indicated that LAB prescription overall improved patient relationships (19.0% of psychiatrists' answers). Psychiatrists reported there was both a perceived increase in trust and a perceived decrease in trust with patients (10.0% vs 6.0%) although there was a decrease in perceived dissatisfaction, hostility, and aggression within the patient relationship with the prescriber (10.0%). Perceived stigma had both reduced and increased (10.0% vs 6.0%). There was a better duration of symptom control (6.0%), lifestyle suitability (10.0%), and a reduced risk of diversion and misuse (13.0%).

Q. What concerns, if any, have patients voiced about receiving long-acting buprenorphine?

Secondary care specialists and PCPs largely agreed that patients were concerned about the reduced number of face-to-face appointments and the reduced interaction with support networks, as well as patients concerned about the duration of effect not being along enough. Nurses and pharmacists differ most with respect to patient-voiced concerns. The concerns range from the reduction in face-to-face appointments to less flexibility in treatment and potential discomfort of administration mode.

Q. As a long-acting buprenorphine prescriber, what steps have you put in place to address any concerns about the reduction in face-to-face treatment services?

In general, approximately 30 to >50% of respondents in each profession either provided replacement e-consults or telephone consults with the prescriber (Figure 12). A further 20 to 30% of respondents in each profession also offered replacement e-consults or telephone consults with a social worker or mental health specialist. Approximately 10 to 20% of respondents in each profession offered take-home-naloxone apart from nurses where approximately 5% offered this service. The promotion of online support groups or online mental well-being resources were reported by between 15 and 30% of the respondents for each profession.

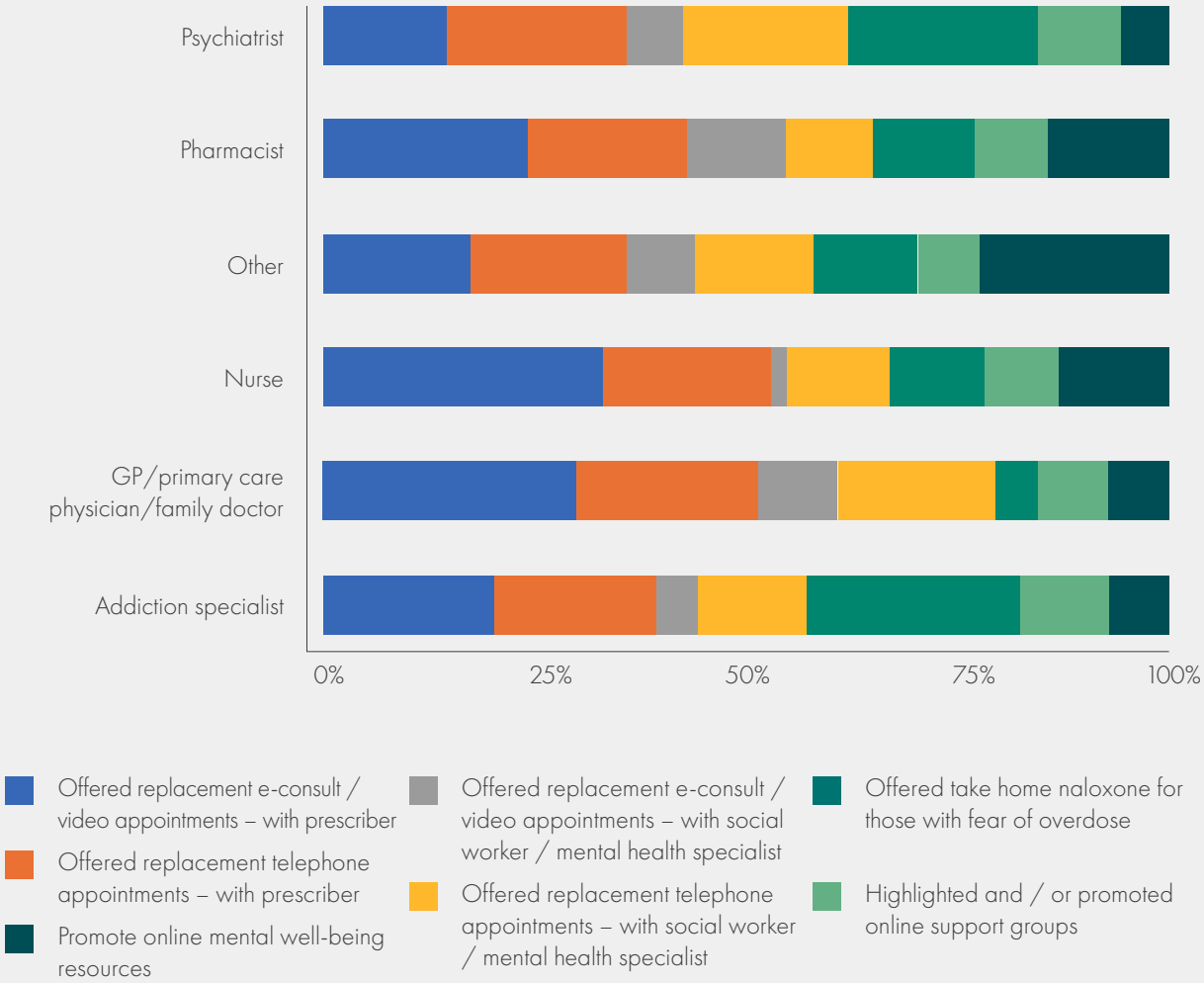


Figure 12. Proportion of responses for solutions to the reduction in face-to-face appointments for each profession.

Q. Are you able to see more or fewer patients since prescribing long-acting buprenorphine formulations?

In general, more than half of respondents in each profession report that they are seeing about the same number of patients since prescribing LAB (addiction specialists = 50.0%, PCPs = 53.0%, nurses = 55.0%, psychiatrists = 54.0%), except for pharmacists where 44.0% reported about the same number of patient appointments. Addiction specialists (23.0%), reported the biggest reduction in patient appointments while pharmacists (44.0%) reported the biggest increase in the number of patient appointments since prescribing LAB.

Q. On average, what proportion of patients receiving the following OST dosing regimens have missed doses?

Daily dose methadone and daily buprenorphine patients are reported to miss the most doses. The monthly and 6-monthly dose buprenorphine regimens are reported to have the fewest missed doses. This may be a result of the high frequency of the daily dose, where one missed dose is not a problem as the next dose comes around soon, offering symptomatic relief from withdrawal or craving. The type of patient with the differing dosing regimens may also be a factor.

Q. For long-acting buprenorphine (LAB) patients, has the greater flexibility or associated freedom with the larger administration window helped aid treatment adherence or compliance?

In general, approximately 80% of respondents in each profession agreed that LAB allowed greater flexibility or freedom regarding the larger administration window and aided adherence and compliance (Figure 13).

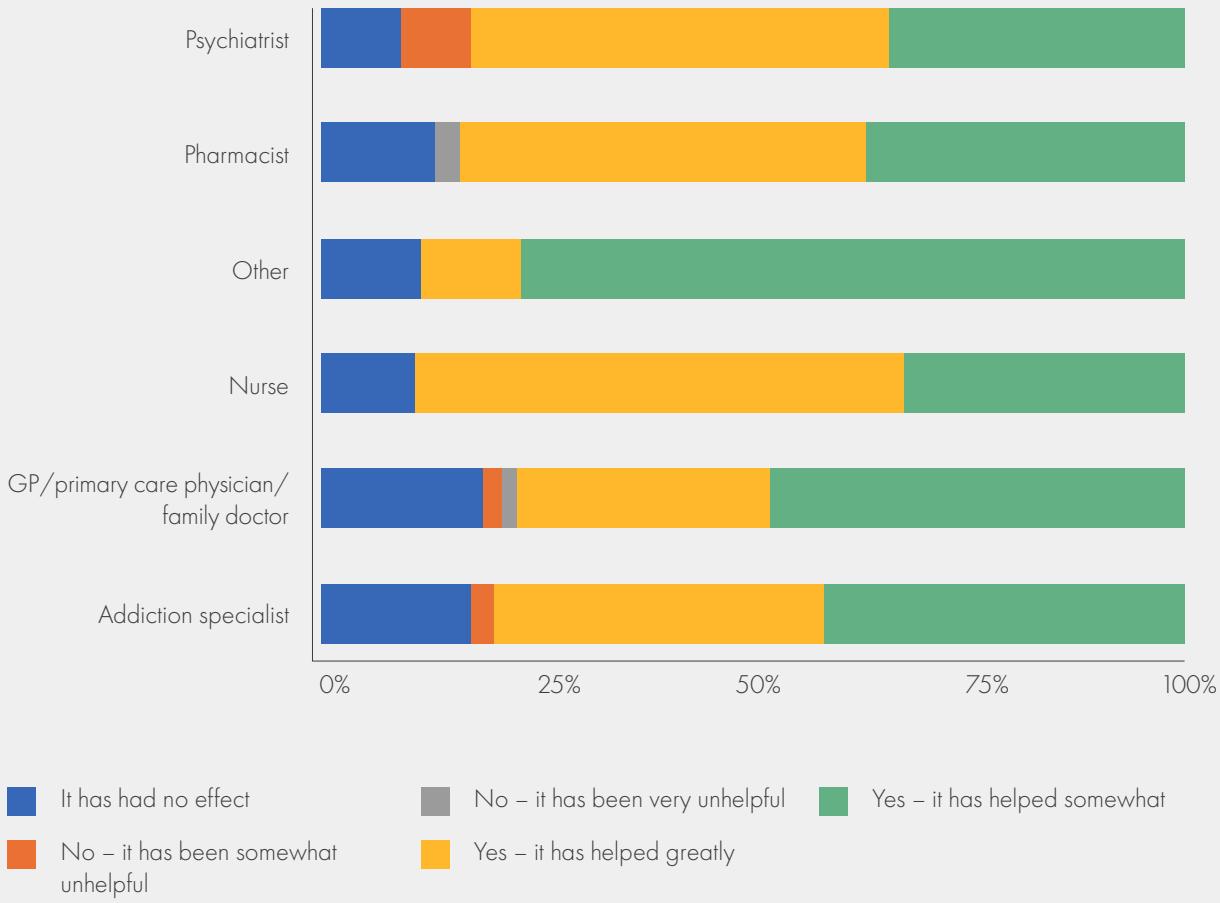


Figure 13. Proportion of responses about the effects of the extended treatment window afforded by long-acting buprenorphine for each profession.

Patient profiling

Q. Approximately, what proportion of your patients are aged within the following ranges?

The majority of patients seem to be weighted towards middle-age and older. Most respondents highlighted an increase in patients from age 30+ (Figure 14).

This may reflect an aging population of drug users, coupled with the possibility that younger drug users may be less likely to seek treatment if they feel their drug use is not problematic or more recreational. The overall numbers of patients in OST are decreasing, however, the age of the average patient is increasing, with currently over 15% of OST patients in the EU aged >40 years of age.[10] In England alone, there are nearly twice as may treatment users aged >51 years of age compared to patients <30 years of age.[11] It could also raise the possibility that some of the prescribers use buprenorphine for pain medication or that younger drug users may be less likely to seek OST. There is also the possibility that the COVID-19 pandemic skewed entry into OST numbers, with fewer people coming forward for treatment.

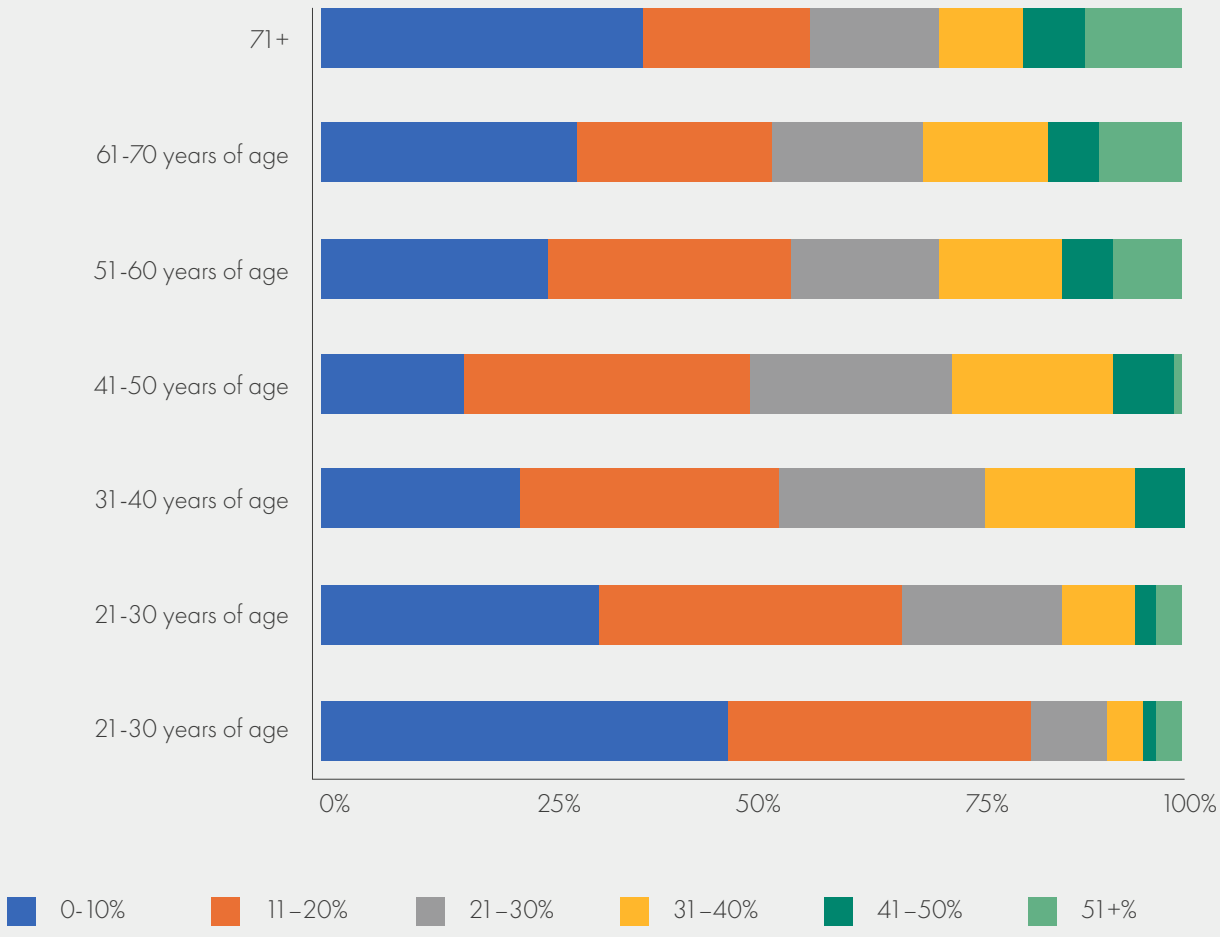


Figure 14. Proportion of patients within specific age bands.

Q. As a prescriber, how important are the following patient attributes for recommending long-acting buprenorphine (LAB)?

All professions considered patient sex and age as unimportant for recommending LAB. However, it may be useful for prescribers to consider patients with young children as potential recipients of LAB, to prevent potential harm resulting from access to daily take-home medication doses.

Primary care specialists considered mental and physical difficulty in attending clinic as important. A consistent daily routine and a strong support network were also considered important. This suggests that education regarding a strong and stable network when transferring to LAB has been successful. A stable home address was considered important by GPs and nurses but not pharmacists. Criminal activity whether regular or non-existent, on the other hand, was considered as neither important nor unimportant. Further education on approaches to minimise misuse and diversion, including the advantages offered by some LAB formulation, may be beneficial for all HCPs.

Secondary care specialists considered mental and physical difficulty in attending clinic as important. A minimal or no support network was considered important for psychiatrists, whereas a strong support network was considered important for addiction specialists. This message seems confusing as a strong support network is important for success and is perhaps an indication that information surrounding the best patient profile for LAB is not being targeted sufficiently. Additionally, daily routine, whether consistent or inconsistent, was considered as neither important nor unimportant for either addiction specialists or psychiatrists.

Regular criminal activity was considered unimportant for addiction specialists when prescribing LAB, whereas psychiatrists considered no criminal activity important. Further information on treatment approaches to reduce stigma may be warranted.

Q. Would you consider, or are you, using long-acting buprenorphine formulations for older/ geriatric opioid-addicted patients?

Across the board, greater than 75% of respondents from each profession indicate that they are prescribing LAB to geriatric patients. Nurses make up the biggest group of professionals who would not consider using LAB for geriatric patients (25%). Further investigation is required to discover the exact reasons behind this trend.

Clinical challenges associated with LAB

What would you consider a barrier to using long-acting buprenorphine (LAB) formulations in your practice?

Cost and access to LAB formulations are the biggest reasons for not prescribing LAB, followed by a lack of patients' preference or acceptance. Nurses and GPs have the biggest concerns with fewer appointments with patients (Figure 15).

For the respondents who had concerns around cold-storage requirement, it should be noted that not all formulations of long-acting buprenorphine require refrigeration.

Q. Please explain how, if at all, do you think treatment with long-acting buprenorphine formulations could be improved or enhanced?

Some suggestions reported were longer duration of effect, lower cost of treatment, better dissemination of information and more educational opportunities, less bureaucracy, more support for mental health, more relaxed storage requirements, and to allow LAB use in prisons where it is currently not in use. To see an increased use of LAB in prisons, respondents would need to work closely to facilitate LAB introduction, where appropriate, and petition their local regulatory bodies using clinical trial evidence on the introduction of LAB formulations into the prison system where available.

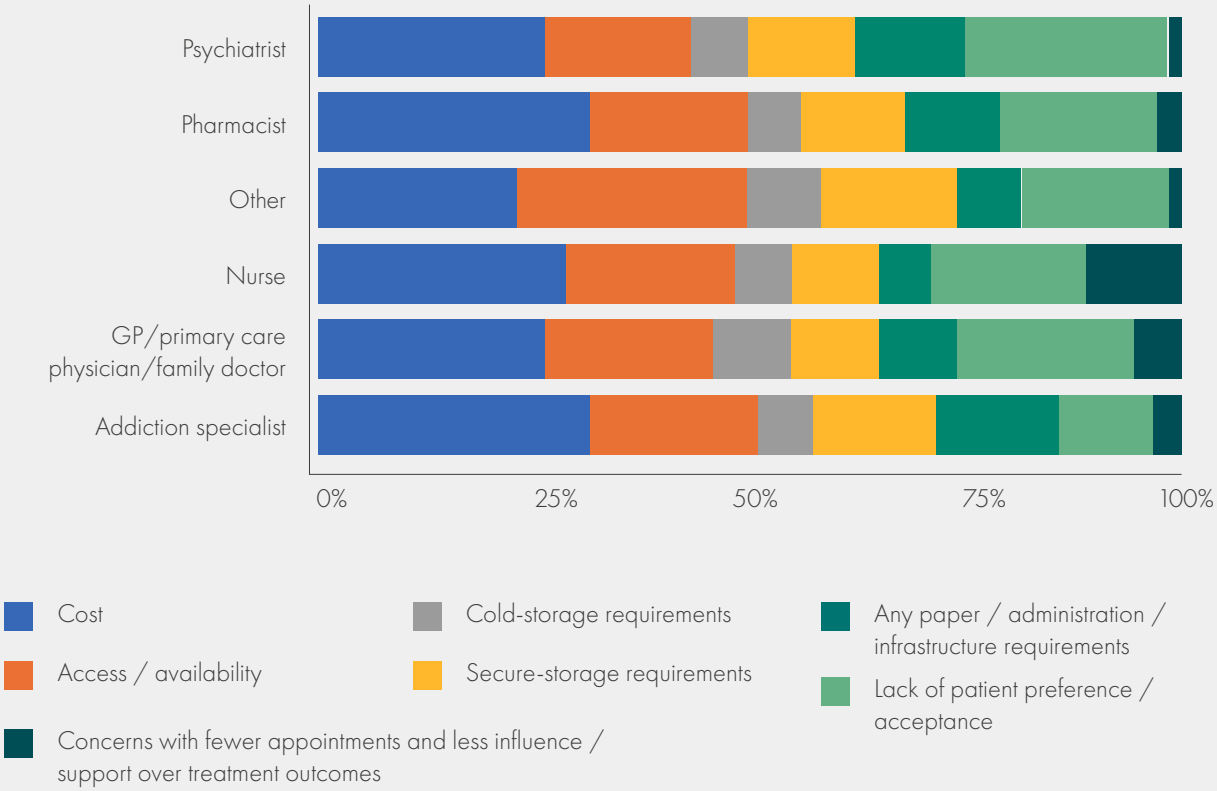


Figure 15. Proportion of answers to potential barriers to increase prescription of long-acting buprenorphine for each profession.

Conclusion

This survey report highlights that access to LAB, and the associated costs, were perceived barriers to increased LAB implementation, however, many respondents indicated a lack of information regarding LAB suggesting that activities and educational promotions raising awareness targeting this may alleviate concerns and increase prescriptions. While the attitudes and practices towards using LAB varied greatly amongst healthcare practitioners, it is important to note that the proportion of respondents currently offering different alternatives to face-to-face appointments is high. More emphasis and education regarding the importance of strong patient support networks (both within the clinic, such as social work, and outside the clinic, such as peer support) for both patient and prescriber may result in greater benefits to patients and better retention. Further education regarding transferring patients from methadone to LAB and improving patient profiling (ensuring the appropriate set-up for support is in place) may also facilitate transfer success and retention in OST.

Greater education surrounding the advantages and disadvantages of LAB formulations – both patient-focussed and practitioner-focussed – and their place in the arsenal of treatment options is warranted. Further insight into the reasons behind the low rates of LAB prescribing by primary care specialists despite higher reporting of LAB as a preferred mode of administration would be interesting. Likewise, further insight could be gathered among secondary care specialists to determine the disconnect between their stated preferred mode of administration and what is reportedly occurring in practise.

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