

# Mainstreaming methadone maintenance treatment: the role of the family physician

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## Résumé

MÊME SI LE TRAITEMENT D'ENTRETIEN À LA MÉTHADONE réussit à améliorer l'état de santé des patients qui ont une dépendance aux opiacés, la stigmatisation des patients traités à la méthadone et des programmes de traitement à la méthadone a toujours un impact défavorable sur les résultats du traitement. Les auteurs proposent une stratégie axée sur les droits de la personne pour le traitement de la dépendance aux opiacés afin d'améliorer l'utilité de l'application du modèle médical au traitement d'entretien à la méthadone. Il faut modifier la perception, le modèle, les politiques et la pratique actuels de l'entretien à la méthadone si l'on veut améliorer la qualité de vie des patients traités à la méthadone. Les médecins de famille ont un rôle crucial à jouer en faisant de l'entretien à la méthadone un traitement d'usage courant et en appuyant la réinsertion communautaire des patients traités à la méthadone qui sont fonctionnellement stables.

**A**lthough recent scientific research supports an understanding of opioid addiction as a chronic *disease*,<sup>1,2</sup> methadone maintenance treatment has not yet gained universal acceptance as a normal therapy for a bonafide medical condition. The perception that methadone maintenance is merely a pragmatic solution to a social problem persists, with the result that its provision is still governed by an intrusive system of regulations most often practised in specialized settings segregated from mainstream medical care. Thus, despite substantial evidence that methadone maintenance achieves good health outcomes such as improved employment status, and reductions in the use of opioids and other drugs (e.g., alcohol and cocaine), drug-related mortality, infectious disease morbidity, criminal behaviour and HIV transmission, its effectiveness in improving quality of life is limited by the continuing stigmatization and social disengagement of patients.

## The experience of stigmatization

Stigma can be fully eradicated only when behaviour is defined without reference to a notion of deviance.<sup>3</sup> Such an approach is provided by the human rights model, which derives its legitimacy from The International Bill of Human Rights<sup>4</sup> and related human rights covenants, under whose provisions freedom to decide, equality or equivalence of opportunity, and the dignity of the person are held to be the inalienable rights of all human beings regardless of their attributes.

### *The primary stigma: "junkie"*

Social scientists use the concept of stigma to refer to a process of social discreditation<sup>5</sup> by which a person's fundamental right to dignity and respect is violated. Historically, the stigmatization of opioid users derived from religious and medical beliefs, by which addiction was viewed as an affliction of weak-willed and morally unsound people incapable of controlling their deviant behaviour.<sup>6</sup> By the late 19th and early 20th centuries, opioid addicts were depicted in popular media as degenerates, and the primary stigma of the "junkie" emerged. The public perception of opioid addicts as "dangerous deviants" who posed a threat to moral



## Editorial

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and socioeconomic stability led to the formulation of laws and social policies intended to impose external controls on behaviour.<sup>7</sup> With the passage of antinarcotics legislation, the secondary stigma of the “deviant criminal” appeared; opioid addicts were dealt with by means of punishment and incarceration, which often involved the systemic violation of their human rights.<sup>8</sup>

### ***From badness to sickness: the medicalization of addiction***

From a human rights perspective, the medical model of opioid addiction has the advantage of shifting blame and guilt from the patient to the disease. In so doing, it offers possibilities for treatment, control and cure. Historically, however, addiction has not been uniformly recognized by the medical profession as a bonafide illness,<sup>12</sup> but has been viewed as a “social problem” that can be corrected only by imposing abstinence as the logical outcome measure of success. In contrast, the pioneers who first described heroin addiction as a metabolic disease and incorporated methadone into a treatment model<sup>9,10</sup> considered the normalization and optimization of function as the primary goal of intervention. By the 1970s, policy-makers in North America recognized methadone maintenance treatment as a means of social control that could reduce drug-related crime. This perception led not only to a marked expansion of programs, but also to increased bureaucratization, regulation and public criticism of methadone maintenance and to a renewed emphasis on the goal of abstinence.

More recently, there has been a shift from strict abstinence-oriented models to broader harm-reduction models, in which abstinence is viewed as 1 of a range of options designed to mitigate the consequences of drug abuse and dependence. Underlying this reorientation are several key factors. First, evidence of human rights violations in institutional settings has led to humane shifts in social policy in favour of deinstitutionalization and community integration. Second, as greater recognition is given to the influence of social and cultural factors on health, broader quality-of-life criteria are being used to measure outcomes. Third, broader public-health approaches have been advanced in an effort to reduce the transmission of HIV associated with injection drug use.

### ***From “junkie” to “methadone zombie”***

The failure of methadone maintenance treatment to mitigate stigma is related in part to misconceptions about methadone as a medication and treatment.<sup>11</sup> Methadone continues to be perceived as a low-status, harmful drug that dulls the senses and is even harder to kick than

heroin.<sup>12</sup> In the subculture of the addict, this has led methadone-maintained patients to be viewed as “zombies,” in contrast with the heroin user’s self-concept as being alert, energetic and capable.<sup>13,14</sup> Misleading media coverage that portrays methadone maintenance treatment as merely replacing one highly addictive drug with another renders methadone maintenance a rehabilitative therapy without honour and negatively affects both the recruitment of patients and their continuation in treatment.<sup>13</sup> Consequently, the “methadone addict” feels isolated from both the “real” and the “addict” world.

### ***The impact of stigma***

As we have noted, the criminalization of opioid addiction has created a punitive and highly regulated environment for methadone maintenance treatment and a single-minded emphasis on the goal of abstinence. This has a significant effect on patients by curtailing lifestyle options, intruding on daily routines and limiting mobility.<sup>15</sup> For patients who are functional and stable, this often multi-tiered regulatory system acts as an invisible jail that imposes unjustifiable restrictions on their human rights and has a negative impact on family life and careers. Finally, licensing requirements that favour a system of specialized methadone providers based in segregated clinics serve to increase the public visibility of “addicts” and to heighten their stigma.

The current practice of methadone maintenance treatment forces patients to conceal their discreditable state of being on methadone. Patients anticipate that disclosure will ruin their reputation and lead to discriminatory consequences such as loss of employment or rejection by friends. Those who do reveal that they are receiving methadone maintenance therapy must constantly “prove” that it does not impair their functioning. Fearing that they will be discredited and ostracized, most remain “closeted,” unable to reveal their enrolment in a program even though most believe it has “saved their lives.”<sup>16</sup> Thus a pattern of voluntary social segregation emerges. The patient leads a double life as someone who is in a methadone maintenance treatment program in private while striving to pass as “normal” in public.<sup>3</sup> Entrapped in this web of duplicity, methadone-maintained patients endure lives filled with anguish, shame, stress and the constant fear of public exposure of their “dirty secret.”<sup>16</sup>

### ***Community-based methadone maintenance treatment***

International experience with community-based methadone maintenance treatment suggests that these programs can be both practical and effective when carried



out by committed practitioners working within a collaborative and integrated system that offers educational, clinical and economic support from specialists and specialized institutions.

In New South Wales, Australia, over 85% of methadone-maintained patients are treated by general practitioners and receive their methadone at community pharmacies.<sup>17</sup> The system is publicly funded and integrated through links to specialized clinics that offer training and continuing education for providers and serve as a back-up support in the treatment of complex cases. Preliminary studies<sup>17</sup> suggest that positive treatment outcomes (e.g., the reduction or termination of heroin use, and increased employment) of this community-based model are comparable to those achieved in specialized clinics.

Further evidence comes from Scotland,<sup>18</sup> where a Community Drug Problem Service stabilizes opioid addicts on methadone and subsequently coordinates a “shared-care” treatment program with community-based physicians. The program provides counselling services, case management and in-service training in physicians’ offices. Greenwood<sup>18</sup> suggests that physicians’ acceptance of the program is high primarily because they view harm reduction as a legitimate public health aim and perceive decision-making as a shared responsibility between them and the specialized addiction centre or specialist. Measures of success include reduced street drug use, lower crime rates and reduced incidence of medical complications associated with intravenous drug use.

A similar collaboration exists in Amsterdam<sup>19</sup> between a municipal health service, which provides a rigidly structured methadone program aimed at initial stabilization, and community-based family physicians. The latter receive patients who are medically insured and perceived as “stable.” The system is fluid and cooperative, allowing the family physician to transfer difficult patients to the municipal service and to receive self-regulated clients from the municipal service. The community physicians involved have demonstrated a voluntary and permanent commitment to the provision of methadone services.<sup>19</sup>

In contrast, in North America only a small proportion of functionally stable methadone-maintained patients are treated by family physicians. In the US, one such project<sup>20</sup> involves a shift in treatment setting from specialized clinics to private practice, where patients report a significant enhanced normalcy and quality of life.<sup>21</sup> Patients experience personalized care and hence more dignity and respect; greater freedom from bureaucracy; enhanced opportunities to expand in social, vocational and educational domains; and enhanced concealment of their stigmatized condition through greater confidentiality.

## Counterarguments

By incorporating a human rights approach in the practice of methadone maintenance treatment, the medical model offers the most constructive paradigm for improving quality of life for opioid-dependent patients. Criticism of our position comes mainly from sociologists who argue that the medical metaphor limits our vision by locating the source of behavioural deviance — the disease of addiction — within the individual. This prevents us from seeing the judgement about what constitutes deviance as a crucial part of the phenomenon. According to this view, the meaning of behavioural deviance (e.g., opioid dependence) is socially constructed<sup>22,23</sup> and can be understood only by taking into account its key socioeconomic and political determinants. Others point out that despite medicalization the “sick” label remains tainted with a “deviant” connotation, and that public ambivalence toward the “deviant” behaviour of opioid addicts persists.<sup>24,25</sup> In practical terms, a number of criticisms bearing on difficulties in recruitment and quality control predominate.<sup>18,26,27</sup> We recognize the importance of the theoretical and practical aspects of these criticisms, but because of space constraints we will address only the practical aspects here.

## Changes in perceptions, model, policy and practice

It is critical that the medical profession formally redefine opioid addiction as a legitimate chronic medical disease. Although methadone maintenance may well serve secondarily to allay certain social problems such as addiction-related crime, dependence on social assistance and the spread of HIV infection, it is first and foremost a medical response to a medical problem. This official redefinition could be promoted widely through consensus conferences organized by methadone maintenance providers and ministries of health, and by the development and distribution to all family physicians of human rights oriented clinical practice guidelines for methadone maintenance treatment. A strong public education mandate could follow.

The US Institute of Medicine<sup>28</sup> has suggested that the development of such guidelines could be followed by changes in policy that would couple the deregulation of methadone maintenance with procedures such as peer-reviewed accreditation. This would allow physicians greater clinical discretion and support and could lead to a dramatic increase in treatment of addicts in mainstream settings.<sup>29</sup>

In North America, the development of a cooperative and integrated system linking family physicians with specialized centres could prove both practical and effective.



Successful recruitment of physicians would be facilitated by the removal of prohibitive educational and licensing requirements and by the allocation of funds for family physician training and continuing education in drug addiction. Strategies for education could include developing a standardized clinical reference manual<sup>30</sup> and involving family physicians in interactive workshops and placements with experienced prescribers.<sup>27</sup> Addiction specialists could be linked to family physicians through a mentor program to ensure continuing education, clinical support and quality control. This model has been demonstrated as a practical one for expanding primary care HIV treatment in Ontario.<sup>31</sup>

## Conclusion

Methadone maintenance treatment has produced highly successful health outcomes for many opioid-dependent patients. However, a profound stigma remains, leading to a shame-filled, closeted existence and an experience of reduced quality of life. Incorporation of a human rights approach is necessary to extend the usefulness of the medical model and to reduce the stigmatization of methadone-maintained patients. To this end, we have suggested changes in the current perception, model, policy and practice of methadone maintenance. Family physicians are needed to integrate this treatment option into mainstream health care, which will maximize opportunities for patients to empower themselves, expand their life opportunities and regain their sense of dignity and self-respect.

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