Methadone maintenance treatment: a Canadian perspective

Bruna Brands, PhD; David C. Marsh, MD

Résumé

LE TRAITEMENT D'ENTRETIEN À LA MÉTHADONE constitue une stratégie efficace de traitement de la dépendance aux opiacés. De nombreux obstacles, y compris les stigmates que la société impose aux consommateurs d'opiacés et aux patients qui prennent de la méthadone, limitent malheureusement l'accès à ce mode de traitement. Dans ce numéro (page 395), les Drs Mark Latowsky et Evelyn Kallen discutent des origines de cette stigmatisation et proposent des solutions possibles. La stigmatisation des consommateurs d'opiacés a toutefois des racines plus complexes que celles que l'on peut traiter par les moyens proposés. Même si beaucoup des mesures que les Drs Latowsky et Kallen proposent sont valables et servent déjà en fait au Canada, il faut aller plus loin et remettre en question les attitudes de la société et des médecins face à la dépendance aux opiacés.

Heroin use is a social tragedy of the late 20th century that affects young people in their prime of life. Heroin dependence is associated with an annual rate of death of 1%[1] and is linked with loss of employment, educational underachievement, increased crime, poor health and the spread of HIV, viral hepatitis and other blood-borne diseases.[2]

Opioid use has been a growing problem in Canada over the past 10 years. In BC, illicit drug use, primarily the intravenous use of heroin and cocaine, was the leading cause of death among 30- to 44-year-old men in 1993.[3] In the same province, deaths caused by drug overdose increased from 39 in 1988 to 331 in 1993; of these deaths, 90% were associated with heroin.[3] Evidence also suggests that heroin use is increasing in Ontario. The quantity of heroin seized by law-enforcement officers escalated from 2299 g to 7983 g from 1991 to 1994.[4] In Toronto, deaths from heroin overdose rose from 12 in 1986 to 45 in 1995.[5] Increased use of heroin in Ontario has been attributed to increased availability of the drug, decreased cost and the higher purity of the heroin available.[4] The situation in Quebec with respect to increased deaths from overdose and growing numbers of heroin users parallels that in BC and Ontario.[5]

Against this background, increased attention has been focused on methadone maintenance treatment, which was first introduced by Dole and Nyswander in 1964.[6] The Addiction Research Foundation has been providing methadone services in Toronto since the early 1970s. Many studies have demonstrated the efficacy of methadone maintenance in reducing use of opioids, decreasing crime associated with drug use, decreasing drug-related deaths and preventing the spread of blood-borne diseases,[7–11] and methadone maintenance has increasingly become standard practice in many countries.[12] Nevertheless, several problems remain.

In this issue Drs. Mark Latowsky and Evelyn Kallen comment on some of the issues faced by health care professionals in the provision of methadone maintenance treatment (page 395). They correctly identify the social stigma attached to opioid users as a barrier to the provision of adequate care. The roots of this complex and multifaceted stigma, they argue, include the public perception of the "junkie," formed in the late 19th century; the misguided belief that people with addictions are weak-willed and could stop if they wanted to; and the perpetuation of these beliefs by the medical system even today.

Bell[13] has identified the attitudes and beliefs of physicians toward opioid users as the primary issue to be dealt with in educating primary care physicians in the

Editorial

Éditorial

Drs. Brands and Marsh are with the Addiction Research Foundation, Toronto, Ont.

The opinions expressed in this article are the authors' and not necessarily those of the Addiction Research Foundation.

Can Med Assoc J 1997;157:399-401

See related articles pages 395, 430

provision of methadone maintenance.[13] Latowsky and Kallen suggest, moreover, that the setting in which methadone maintenance treatment is currently provided perpetuates rather than decreases the stigma attached to opioid use. In North America, provision of this treatment has traditionally been restricted to specialized clinics.[14] Misconceptions about the pharmacologic properties of methadone and about the rationale for methadone maintenance abound, both in the subculture of addiction and in the mainstream media.[15] The small proportion of methadone users who have more severe psychopathologic conditions or who continue to abuse sedatives, alcohol or both tend to be more visible when treated at specialized clinics and to colour the public perception of this treatment option.[13] Much less visible are the majority of methadone patients, who move quickly toward social reintegration. In fact, these successful patients tend to avoid publicizing the fact that they are receiving methadone because of the very stigma that they are in a position to challenge.

Latowsky and Kallen propose 3 potential solutions to the problem of stigmatization. The first is for the medical profession to "formally redefine opioid addiction as a legitimate chronic medical disease." They feel that the adoption of a "human rights orientation" will increase physicians' awareness that the provision of methadone is an appropriate medical response to a chronic illness and will improve quality of care. They suggest consensus conferences and the publication of prescribing guidelines as vehicles for promoting this approach. They suggest that methadone prescribing be deregulated and that licensing be replaced with peer-reviewed accreditation. Their third proposal is to encourage the provision of methadone maintenance in community settings for primary care.

Clearly, Latowsky and Kallen are correct in identifying the stigma attached to opioid use and methadone maintenance as barriers to adequate care. However, their proposed solutions need to be expanded and modified. The attitudes and beliefs of physicians reflect those of society and can interfere with their involvement with these patients. However, this is more appropriately addressed through education that addresses attitudes, values and beliefs surrounding substance-use disorders. Educational initiatives, such as Project CREATE (Curriculum Renewal and Evaluation of Addiction Training and Education) in Ontario's 5 medical schools and the training courses currently offered in Ontario and BC for clinicians seeking methadone licensure address this issue with undergraduate medical students and practising physicians. The removal of licensing and educational requirements would only prevent physicians who are interested in prescribing methadone from benefiting from these initiatives. Moreover, as the authors point out, some patients feel that receiving methadone in community practices only leads to further concealment of their stigmatized condition. Although this observation identifies a legitimate problem, solutions that Latowsky and Kallen propose are unlikely to overcome it. The reality is that patients can be stigmatized in any setting; the real, but more complex, solutions lie in improving public education, making the successes of methadone treatment more visible, legitimizing the view of opioid dependence as a medical disease and challenging society's underlying prejudices.

That being said, there is value in providing methadone services as part of primary medical care in the community and thus increasing access to much-needed treatment. Increasing the availability of methadone maintenance treatment would decrease the tragic loss of life caused by opioid overdose, help to prevent the spread of HIV infection and other diseases and improve the quality of life of people with opioid dependence. It is important, however, that this increase in care provision in the primary care setting be supported by specialized clinics. The reality is that opioid dependence is a chronically relapsing condition and some patients will require the concentration of resources that is possible only at specialized clinics.

Some of the solutions that Latowsky and Kallen propose are already being applied in parts of Canada. BC and Ontario have formal training courses for physicians interested in prescribing methadone. In Ontario, such training has been extended to pharmacists to ensure continuity of care. Also in Ontario, the Addiction Research Foundation, the College of Physicians and Surgeons of Ontario (CPSO) and the Ontario College of Pharmacists have collaborated in establishing guidelines that articulate the current standard of practice in methadone maintenance treatment. A training manual has been developed to help physicians apply these guidelines in clinical practice. Methadone services in BC are provided by physicians in private practice or through clinics comprising 6 to 12 physicians. In Ontario, services are provided at specialized clinics, community health centres, clinics comprising several methadone prescribers and individual family physicians. In Quebec, services are delivered through specialized clinics and primary care physicians. Beginning with BC and continuing with Ontario, concerted efforts have been directed toward increasing the number of physicians licensed to prescribe methadone in a community family practice setting. For example, in July 1996 the CPSO assumed responsibility for the administration of methadone services for the province of Ontario from the Bureau of Drug Surveillance in Ottawa. Over a 9-month period, the number of physicians actively prescribing methadone across Ontario increased by 60%, while the number of patients in methadone treatment has almost doubled

(John Brands, CPSO, unpublished data; 1997). It is important to note that most of the recommendations made by Latowsky and Kallen have, in fact, already been implemented in Canada. These and other initiatives being taken in BC and Ontario in particular will improve the availability of methadone maintenance treatment. However, challenging the stigmatizing views of some medical professionals and of society at large will require not only better treatment access but educational and advocacy efforts at many levels.

References

1. Baden M. Methadone-related deaths in New York City. *Int J Addict* 1970; 5:489-98.
2. Ralston GE, Wilson P. Methadone programmes: the costs and benefits to society and the individual. *Pharmacoeconomics* 1996;10:321-6.
3. *Report of the Task Force into illicit narcotic overdose deaths in British Columbia*. Burnaby: Office of the Chief Coroner, Ministry of the Attorney General; 1994.
4. Metropolitan Toronto Addictions Treatment Services Committee. *Heroin activity in Metropolitan Toronto*. Toronto: The Committee; 1995:5.
5. Research Group on Drug Use. *Drug use in Metropolitan Toronto*. Toronto: The Group; 1997:12.
6. Dole VP, Nyswander M. A medical treatment for diacetylmorphine (heroin) addiction: a clinical trial with methadone hydrochloride. *JAMA* 1965;193:80-4.
7. Ball JC, Ross A. *The effectiveness of methadone maintenance treatment: patients, programs, services, and outcomes*. New York: Springer-Verlag; 1991.
8. Hubbard RL, Marsden ME, Rachal JV, Harwood HJ, Cavanaugh ER, Ginzburg HM. *Drug abuse treatment: a national study of effectiveness*. Chapel Hill (NC): University of North Carolina Press; 1989.
9. McGlothin WH, Anglin MD. Shutting off methadone: cost and benefits. *Arch Gen Psychiatry* 1981;38:885-92.
10. Metzger DS, Woody GE, McLellan AT, O'Brien CP, Druley P, Navaline H, et al. Human immunodeficiency virus seroconversion among intravenous drug users in- and out-of-treatment: an 18-month prospective follow-up. *J Acquir Immune Defic Syndr* 1993;6:1049-56.
11. Simpson DD, Sells SB. Effectiveness of treatment for drug abuse: an overview of the DARP research program. *Adv Alcohol Subst Abuse* 1982;2:7-29.
12. Maremmani I, Reisinger M. *Methadone treatment in Europe*. European Methadone Association Forum, 1995 Oct 13; Phoenix, Ariz.
13. Bell J. Alternatives to non-clinical regulation: Training doctors to deliver methadone maintenance treatment. *Addict Res* 1996;3:315-22.
14. Lowinson JH, Marion IJ, Joseph H, Dole VP. Methadone maintenance. In: Lowinson JH, Ruiz R, Millman RB, Langrod JG, editors. *Substance abuse: a comprehensive textbook*. 2nd ed. Baltimore: Williams and Wilkins; 1992.
15. Hunt DE, Lipton DS, Goldsmith DS, Strug DL, Spunt B. "It takes your heart": the image of methadone maintenance in the addict world and its effect on recruitment into treatment. *Int J Addict* 1985–1986;20:1751-71.

Reprint requests to: *Dr. Bruna Brands, Addiction Research Foundation, 33 Russell St., Toronto ON M5S 2S1; bbrands@arf.org*