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▶ Alternatives to non-clinical regulation: training doctors to deliver methadone maintenance treatment.

Bell J.

Addiction Research: 1996, 3(4), p. 315–322.

Seminal study of how to train out socially derived attitudes to methadone maintenance as a policy solution to a social problem and train in attitudes which place it within mainstream medical practice as a treatment of individuals which does not 'fix' their problems but offers the opportunity for positive change.

Summary This account is based on the description of the study in the chapter by the same author 'Training health professionals to deliver methadone treatment' in the book Methadone maintenance treatment and other opioid replacement therapies.

In the Australian state of New South Wales training for medical practitioners in the delivery of methadone maintenance treatment has comprised a written manual, an interactive workshop, and a supervised clinical placement. The training has been evaluated and progressively modified in the light of feedback from participants and observers.

Main findings

Participants liked the training and particularly valued the use of clinical vignettes and case studies. Six to 18 months after undertaking training most trainees indicated that they were prescribing methadone, and expressed a strong interest in continuing education and peer support. However, a one-day interactive workshop was commonly felt too short to cover all the material.

The most valuable feedback on the training process came from observers who attended the first four workshops. Observers and facilitators met after each workshop to identify

difficulties. It quickly became apparent that the key challenge did not relate to lack of knowledge, but to the assumptions and attitudes of medical practitioners.

Attitudes to addicts and addiction which were most problematic were those which polarised at two extremes. At one were practitioners who expressed negative views of drug users, and who saw the goal of treatment as being to achieve abstinence from all drugs. For these doctors, the justification for methadone treatment was that it helps control deviant behaviour. Their understanding was that methadone is offered to patients in return for compliance with the expectations of the prescriber. This contractual understanding essentially sees methadone as a system of rewards and punishments to encourage patients to become abstinent and be less antisocial.

At the other extreme were trainees who expressed more positive views of addicts, seeing them not as individuals with problems, but people making lifestyle choices discriminated against by social policy. For these 'progressives', there is little inherently problematic about dependence on heroin; rather, the problems associated with heroin addiction arise because the drug is illegal, and supplies are therefore expensive and impure.

Both perspectives conceptualise methadone maintenance as a system of controlled drug distribution to reduce the harmful consequences of heroin addiction. For both, and for many politicians and administrators, methadone maintenance is a pragmatic solution to a social problem, rather than a treatment of individuals. In this frame of reference, regulations about how methadone should be prescribed and dispensed are more relevant than principles of treatment.

To the committee organising the training, this frame of reference was problematic. It identified methadone treatment as different from 'mainstream' medical practice, not part of the duty of care owed to individual patients seeking treatment. Within the regulatory framework, usual assumptions about patient care are often not seen as applying; rather, any practices which fit within the regulations are acceptable. In contrast, 'treatment' involves assumptions about individual patient care and professionalism which are a better defence against poor practice than regulations.

A related problem identified in the workshops was that many practitioners had difficulties coming to terms with the motivational and interactive nature of the treatment of dependence. They expected clear guidelines on how to respond to clinical problems, for example, on how to respond to benzodiazepine abuse among patients on methadone. Instead of clear directions, it was suggested that responses depended on what the patient was willing or able to do, and that even when a plan was negotiated, they should not be surprised if it was not adhered to. They found difficulty with the suggestion that sometimes the most helpful response is to advise, wait and observe, and avoid being provoked into fruitless attempts to control patients' behaviour. Treatment as something passive which at best *permits* change to occur is unfamiliar and challenging to those trained in a biomedical framework. The frustration of working in this way is another obstacle to seeing methadone maintenance as a 'real' form of treatment.

Addressing the problems identified in training

Manual and workshop were progressively modified in the light of these problems. The first session of the workshop became devoted to exercises exploring trainees' attitudes to addicts and addiction. Most doctors share community antipathy towards heroin users, for

many exacerbated by occasional experience of treating difficult, hostile, drug-seeking patients. Such experiences often give rise to an adversarial approach to treating heroin users. An exercise to address these difficulties was adopted to place methadone treatment in the context of medical practice, identifying the types of patients doctors find difficult. Heroin users presented as examples of patients embodying many of the traits which doctors find difficult. The skills needed to respond appropriately were emphasised as generic skills of value in all areas of medical practice.

A similar approach was adopted to deal with beliefs about heroin addiction. Here too, practitioners tend to reflect community assumptions about addiction to heroin, and a crucial aspect of training was to avoid either exaggerating or trivialising the problems. This was addressed by considering problems of dependence on a variety of drugs − benzodiazepines, alcohol, tobacco − and to the biopsychosocial factors promoting vulnerability to dependence.

Frustration provoked by patients who continue to abuse drugs while in treatment was addressed by modifying both manual and workshop to clarify that treatment of dependence is permissive − not *causing* people to change but *allowing* them to do so. The goal is to allow patients more control over their lives. Treatment with methadone can reduce the level of behavioural dependence on opioids, allowing patients the opportunity − depending on their circumstances − to lead more normal and productive lives. The fact that some are unable to take advantage of this respite is something clinicians and policymakers must acknowledge.

The final and perhaps most important lesson from the training programme was to recognise the limitations of a single training session, particularly in dealing with attitudinal issues. A system of continuing education, based around case discussions and clinical problems, has now been developed.

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