

'Being a useful puppet'

A study of municipal medication-assisted rehabilitation in Norway

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Abstract: The issue addressed by this study is informed by the experiences of employees in community services in medication-assisted rehabilitation (MAR) in relation to current practices. The study was carried out in a Norwegian municipality with 53,000 inhabitants. An electronic questionnaire with multiple choice answers and options for freetext responses was issued to 11 municipal employees and 13 general practitioners (GPs). The municipal employees perceive the current MAR system as deficient. The diversity of the patients gives rise to great variation in professional experience. Cooperation and follow-up is to a very great extent dependent on the individual concerned. The respondents also state that the medical aspect of MAR work has become overly predominant, and call for a more systematic approach to improve common professional understanding, division of responsibility and coordination. The material suggests that each general practitioner attends to too few MAR patients to be able to accumulate sufficient expertise in treatment and care pathways. Current practice, where general practitioners often feel themselves as 'being useful puppets in the MAR system', is regarded with relatively high dissatisfaction. Respondents in this Norwegian study assert the need to consider a more centralised form of organisation releasing general practitioners from MAR responsibility. In the analysis, the focus was on how municipal employees and general practitioners interpret MAR. This led to various reflections and issues of concern arising out of the materials obtained.

Keywords: Medication-assisted rehabilitation (MAR); community follow-up; cooperation; organisation

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Date of first (online) publication:

Introduction

The purpose of the study has been to investigate the nature of experiences of employees in community services for medication-assisted rehabilitation. The study sheds new light on what works well, and what works less well in the current municipal medication-assisted rehabilitation (MAR) system from the perspective of municipal MAR care-workers and general practitioners. The MAR system entails controlled provision of methadone or Subutex/Suboxone and functional follow-up at local level.

Substitution rehabilitation for opioid dependence (STO) became generally available in Norway from 1998, and from 2001 was termed Medication-Assisted Rehabilitation. Initially, rehabilitation was organised within regional centres, but, from 2004, these functions were incorporated into the specialist health service as a component of Interdisciplinary Specialised Treatment (IST). In 2010, specific regulations were introduced, as was a set of new national MAR guidelines (Norwegian Directorate of Health, 2010).

The basic organisational model for this form of treatment is a tripartite interdisciplinary programme between the municipality, general practitioner and specialist health service. In the municipality investigated in this study, this is the model in operation. The specialist health service's IST is provided by the social medicine outpatients' clinic (SMP). The GPs are responsible for the continuity of medical supervision, including for patients undergoing MAR. The municipality discharges its share of responsibility through a dedicated team of employees responsible for local follow-up of MAR patients.

Data forming the basis for this report were gathered by means of an electronically issued questionnaire in 2011, in order to secure anonymity and making means of response as easy as possible for the respondents. The study was confined to the situation as it exists in the municipality studied. Other regions and counties may be under different organisation, and hence give rise to other experiences.

Background

The survey among municipal employees was conducted from October 2011 to February 2012 and included 11 respondents. This figure represents all those who at the time of the survey were directly involved in local MAR follow-up or administration. In the text, members of this group are at times referred to as substance abuse workers.

The survey among GPs was conducted from October to December 2011 and had 13 respondents. This figure represents around half of the GPs with MAR patients in the municipality at that time. The majority have limited experience of attending to MAR patients; only a few of them have more extensive experience.

Literature review: National and international research on MAR

Medication-assisted rehabilitation (MAR) has been available in Norway since 1998, and was referred to as 'Substitution therapy for opioid dependency' from 1998 until 2001, when the programme was renamed MAR. This form of therapy was originally developed in the 1960s by the doctor Vincent P. Dole and the psychologist Marie Nyswander. They discovered that methadone can remove drug addiction and that maintenance doses can restore drug addicts to a productive life. Their hypothesis was that heroin addiction is a metabolic syndrome, and that methadone can be used as a medication for treating this condition. In the mid-1960s, Dole and Nyswander started a local programme for treating drug addicts with methadone, and in the decades that followed, similar programmes have become widespread in every part of the world (Courtwright, 1997).

In 2011, the University of Oslo (UiO), Department of Clinical Medicine carried out a major systematic review of national and international research on MAR (Bramness et al., 2012). A total of 884 national and international publications were initially found on the topic, but after having discounted studies because of lack of relevance, they were left with 169 publications. The majority of these studies concern medical aspects of MAR, and only a few studies concerned the experiences gained by health professionals. Bramness et al. (2012) have divided the publications into the following topics:

1. MAR generally (33 articles)
2. Pregnancy in MAR (29 articles)
3. Adverse effects of MAR medication (27 articles)
4. Pharmacology of the substitution medications (19 articles)
5. Buprenorphine as MAR medication (17 articles)
6. Co-morbidity, mostly psychiatric, but also somatic illness (11 articles)
7. Mortality (8 articles)
8. Misuse of other substances (7 articles)
9. Pain in MAR patients (6 articles)
10. Hepatitis C (5 articles)
11. Crime (4 articles)
12. Heroin substitution (3 articles)

Although pregnancy in MAR is second highest in the list of publications on MAR, knowledge is still lacking on the effect of medication administered to pregnant women on MAR programmes. This emerges from a study conducted by Lund et al. (2012) at the Norwegian Institute of Public Health. In this study, which included 138 women in MAR together with 159 pregnancies between 2004-2010, it was revealed that 80 per cent of the women were also taking other prescription medications during pregnancy.

The question of MAR being able to reduce mortality and to improve somatic and mental health in opioid misusers was investigated in a Norwegian undergraduate thesis at the medical faculty of University of Oslo where 26 MAR patients were interviewed (Brekke et al., 2010). The results indicated that quality of life in MAR patients was influenced in a positive direction in that they were no longer controlled by their addiction, had fewer social problems, and had better relationships with family and friends. However, the study did reveal that MAR patients were still prone to loneliness and isolation, which had an adverse effect on their quality of life.

In a study carried out by Stubberud et al. (2007), comprising 40 patients with opioid dependency undergoing MAR, one of the findings was that treatment failed because the individual lacked the cognitive prerequisites for receiving and processing the information that is essential for successful rehabilitation. Another finding was that the co-existence of a personality disorder might be involved in reducing the likelihood of a positive therapeutic process. The reasons for these failures are not given in this study.

In Norway, the conclusion is that MAR is largely rated highly by doctors. This emerges from a study conducted by Waal et al. (2012) and which includes 1,165 GPs. Although MAR requires extended cooperation between GPs, social services and the specialist health service, the GPs in this study looked favourably on this cooperation and had few objections to the GP's role in the Norwegian MAR model, despite the fact that the model, to a certain extent, imposes some limitations on the individual doctor's autonomy,

Heroin-assisted rehabilitation, which is not permitted in Norway, has been found to be effective in people with opioid dependency. Haasen et al. (2007) conducted a large-scale German study involving 1,015 heroin addicts, in which the conclusion was that this form of treatment is especially effective in cases where the patient continues to use heroin intravenously whilst concurrently undergoing methadone rehabilitation or where the patient receives no medication. In this instance, effectiveness was rated in terms of improved physical and/or mental health and a reduction in illicit use of narcotics.

A Danish study on whether psychosocial support in methadone rehabilitation is conducive to improved treatment outcomes, especially in terms of psychological and social objectives, revealed numerous difficulties concerning the use of empowerment in this patient group (Frank & Bjerger, 2011). This study included interviews with 26 treatment providers and 37 patients. One of the difficulties proved to be that this form of treatment is affected not only by the treatment provider/patient cooperation, but also by municipal economic frameworks and healthcare regulatory guidelines. This entails a controlling role on the part of the treatment provider in order to prevent the use of supplementary illicit narcotic substances while the patient is on a rehabilitation programme where methadone is administered. This controlling role on the part of the treatment provider conflicts with the ideal of empowering the patient in relation to his or her own treatment programme.

In order to understand the precursors for the approach to and practice of MAR, this study focuses on the principles embodied by public policy instruments. This may be seen as a deconstruction of policy pursued in this area. In terms of the policy-based sociological approach, the various public policy instruments employed are not neutral tools; at times they produce effects consistent with the intended goal, and at times an instrument simply follows its own logic (Lascoumes & Le Gales, 2007, p.4). The public policy instruments considered here are the Norwegian Health Service Reform for Substance Abusers from 2004, the MAR regulations (last amended in 2010) and the national guidelines from 2010. The object of these instruments is to guide public-sector employees in a certain direction to make them think or act in a manner they would not otherwise have considered (Salamon 2002, Lascoumes & Le Gales, 2007). In conjunction with other healthcare and social legislation, these constitute a governing framework which municipal employees and GPs are required to abide by in practising their profession.

A policy-based sociological approach reveals the substantial frameworks surrounding MAR. Every single instrument constitutes a condensed form of knowledge concerning social control and the manner in which it is exercised. These public policy instruments are tangible and operational, but they are not neutral; they are rather the bearers of values prescribing interpretations and opinion (Lascoumes & Le Gales, 2007; 4). An analysis of these instruments gives us an opportunity to elucidate dimensions of public policy in this area which would otherwise be difficult to find.

Method

The request to participate was sent out by email based on the specialist health service's list of GPs with MAR patients and based on the municipal medical officer's list of municipal employees with responsibility for MAR follow-up. The survey consisted of 29 questions or statements for the respondent to consider. The questions fall into four categories: perspectives on the patient group; attitude to regulations and guidelines; experience of cooperation; and competence requirements.

The combination of multiple choice answers and freetext responses provided a fair impression of the types of experience, challenges and problems given by the respondents.

The survey received responses from all of the municipal employees responsible for direct daily follow-up of MAR patients in the municipality at the time of the survey. As such, the results may be regarded as highly representative as regards municipal work vis-à-vis the target group.

The respondents were asked to tick boxes against alternatives relating to statements concerning various topics. In addition, in several sections of the form,

the respondent had the option of entering freetext comments and detailed responses. These comment fields were used extensively by the respondents.

The fact that we received completed questionnaires from all of those responsible for the main work with MAR patients give grounds for a reliable picture of MAR treatment in this municipality.

The study was submitted to the Norwegian Social Science Data Services (NSD), assessing the project in relation to the provisions of the Personal Data Act and Personal Health Data Filing System Act. All the information in the study is based on anonymised forms in order to prevent data being linked to individuals. The study adhered to the ordinary rules for ethical research prescribed by the National Committee for Research Ethics in the Social Sciences and the Humanities (NESH).

Findings

The questions concerning perspective on the patient group give us an overall impression of a field of work heavily influenced by a medical perspective, and where the predominant focus on substance abuse means that other diseases and problems are difficult to follow-up.

Both GPs and substance abuse workers found the patient group demanding, but unlike the municipal employees, the GPs prefer not to take on more MAR patients. It would seem as if they do not fit into the GP's everyday practice, or because of a strenuous burden of work. Several GPs stated that they felt like 'being a useful puppet in the MAR system'.

As for the attitude to regulations and guidelines, there seems to be some differences in the responses from the two groups. The municipal employees hold that national guidelines for their work are readily available, comprehensible and workable, while the GPs do not look favourably on them and are more negative about these types of public policy instruments.

The questions concerning cooperation reveal that cooperation with the more technical and instrumental services performed by the on-call doctor and pharmacy are perceived as a boon for both parties. But where arrangements are not explicit and the content more complex, perceptions of continuity are more divergent. The municipal employees appear to maintain a culture of cooperation that means they get along well both with their co-workers, the GPs and the specialist health service. The GPs value cooperation with municipal employees highly, but would seem to be affected by lesser cooperation amongst themselves and a somewhat ambivalent relationship with the specialist health service. Some of them also hold that the specialist health service should take over medical responsibility entirely, releasing GPs from this work.

The competence requirements differ for the two groups surveyed. The municipal

employees state that they largely have what they need in terms of assessment tools and methods for dealing with the target group, while several of the GPs report a lack thereof. Municipal employees would like more on legislation and guidelines, while the GPs call for insights into substance abuse issues, legislation and methods.

The overall impression is that competence is perceived as comprehensive and satisfactory within the municipality, and more deficient among the GPs. This might be an indication that the entire professional field surrounding MAR patients is better geared to professionals with a more social science perspective than to those with a more narrowly medical perspective.

Perspectives on the patient group

The responses under this category reveal three key dimensions of great import for the MAR patients. The first of these concerns norm-deviation. People who take illicit drugs are doing something that is condemned, looked down upon and associated with a great many other negative attributes. Stigmatisation is an apt term to cover this phenomenon (Goffman, 1963).

Stigmatisation is based on categorisation and ensuing typification. Diagnostic systems are also a type of categorisation in which symptoms may be regarded as a form of typification. The mechanisms are parallel: a (negative) characteristic places the person within a group which is ascribed certain traits and attributes. Other aspects of the individuals in the category lose significance or become invisible as soon as stigmatisation has occurred (Pettersen 2009, 2013).

Both GPs and substance misuse workers perceive the patient group as demanding. But unlike the municipal employees, the GPs would prefer fewer, rather than more, MAR patients. This is suggestive of a patient group that tends to be alien to the primary care doctor's everyday practice. These patients have a reputation for being demanding, manipulative and at times threatening. The behaviour they display may have a disruptive effect on daily life at the doctor's surgery, and the typification associated with the stigma may be perceived as threatening for other patients. The MAR group is a bad fit with the ordinary flow of patients.

The study confirms that each GP normally has one or a just a few MAR patients. Presumably this provides a poor basis for developing care pathways, and methods conducive to more streamlined and targeted work with MAR clients. Some of the statements tell us that GPs feel helpless in dealing with this group. They do not see treatment of the condition through to the end and feel exploited by the health service 'being a useful puppet in the MAR system' which they have no control over.

Having GPs follow up MAR patients is not only a practical issue. Part of the underlying intention is to promote normalisation and counteract specific care in that these patients are to use the same services as the rest of the population (Wolfensberger, 1972). Based on the responses we received from the GPs, there

are good reasons for questioning whether the current system is good for the user's situation or not. The challenges of achieving normalisation in everyday professional practice may mount up to the point where the opposite might well happen. What was intended to promote normalisation might also promote stigmatisation and demands for specific care.

The second dimension concerns the dominant position of the medical paradigm. Drug dependence, from the perspective of human health, is defined as a disease. The intense focus on the medication regimen and dependency problem may hinder follow-up of other concomitant disease, and discussions concerning other forms of understanding than the purely medical. Some of the GPs, and, to a great extent the substance abuse workers, believe that life mastery and rehabilitation are given insufficient emphasis in the current MAR system. Behind this, there lurks a subcurrent of barely concealed scepticism and judgmentalism. MAR users are, by definition, patients, but are they actually, in a true sense, ill? Or is there a hint of self-inflicted illness here? In the GP material we find tendencies to condemn those who have 'wangled their way back into respectable society'.

It might seem that stigma is still alive and well, while the justification for and legitimisation of practices have taken a medical turn. One of the harshest aspects of stigmatisation is that the sufferer frequently shares the general public's norms and attitudes regarding the phenomenon concerned. This may produce a negative attribution process causing low self-esteem and negative self-image in the stigmatised individual (Hogg & Vaughan, 2011).

The third dimension concerns self-pathologisation. Different pathologisation processes take place in many directions and at many levels in society (Brinkmann, 2010). There are many battles ongoing to assert the ruling definition as to what constitutes disease and wellness, and healthy and unhealthy. Substance addiction is linked to a stigmatising pathologisation. Instances, where the desire to be diagnosed stems from the substance abuser him/herself, may be termed self-pathologisation. Here, the substance abuser actively takes the initiative for being classified as having a disease. In this case, there are several reasons why the substance abuser might wish to receive a diagnosis. Firstly, he or she might do so in the interests of being accepted on a MAR programme, that is, in order to qualify for medication. Secondly, a diagnosis will have the effect of absolving the individual and his or her surroundings of responsibility. The substance abuser simply has an illness. There is no room for interpretation as to why the person has been given the diagnosis, or questions about the person's milieu, social relationships with family and friends, housing situation, education/employment, interests/recreation. Once branded as having a disease, there is a risk of the person slipping into the identity of being a patient facing life-long addiction, with no other options for being restored to society. Yet often, pathologisation is also the result of a humanistic philosophy that seeks to prevent individuals feeling responsibility for something they are genuinely not responsible for – for the very fact that they are sick (Brinkmann, 2010:281).

Having linked stigma to a disease category it is conceivable that this compounds the substance abuser's low self-esteem and inaction. Aside from the powerful addiction itself and the many potential side effects of the substitution medication, the addict has now had it confirmed that he or she is a hopeless person with a disease that is near impossible to get rid of. The person has become a passive and helpless patient, as opposed to an agent of their own destiny with responsibility for his own actions (Nygård, 2007). The material seems to reflect that normalisation has gone awry.

Experiences of MAR regulations

Findings in this study suggest that municipal employees and doctors perceive the current MAR system as deficient in several key respects. As for the attitude to regulations and guidelines, there are significant differences in the responses from the two groups. The municipal employees hold that these national guidelines for their work are readily available, comprehensible and workable, while the GPs do not look favourably on them.

Substitution therapy for opioid dependency was, as stated, generally available in Norway from 1998. Compared with other countries, Norway was a relative late-starter in substitution rehabilitation. Initially, rehabilitation was organised within regional centres, and from 2004, to coincide with the launch of the reform for substance abusers, these functions were incorporated in the specialist health service under the concept of interdisciplinary specialised treatment (IST).

From January 2004, the regional health trusts took over responsibility for specialist health services for substance abusers (Proposition to the Odelsting, no. 54, 2002-2003). Initiatives that formerly fell within county remits (under the then Social Services Act) were devolved to the state. The municipalities retained both coordinatory responsibility for the services and responsibility for initiatives at municipal level. Meanwhile, substance abusers acquired rights under the Patients' Rights Act. They became patients. This new reorganisation should be seen in the context of the Hospitals Reform of 2002, where the former county hospitals and treatment institutions were organised into health trusts under state ownership (Proposition to the Odelsting no. 66 (2000-2001) on the act on health trusts etc.).

The overriding aim of the reform for substance abusers was for them to receive improved healthcare services embodying integrated services, and for treatment outcomes to improve (Ministry of Health and Care Services, 2004). Notably, it was important to secure better services for patients with complex needs for drug rehabilitation. In relation to service provision and treatment outcomes, *quality* was a key concept. Certain criteria were now set for what constituted good quality in the services, these being interdisciplinarity from social science and health science perspectives, the integration of care, and individually adapted treatment. A group

of people who had long been discriminated against within the health service were now to have easier access to healthcare, and the quality of the interdisciplinary specialised services for substance misusers was to be improved.

Following the reform for substance abusers of 2010, fresh amendments were introduced to the governing frameworks. The new MAR regulations came into effect on 1 January 2010, and the Directorate of Health published the National guideline on medication-assisted rehabilitation for opioid dependence (IS 1701) with effect from February 2010. The object of both of these public policy instruments is to regulate organisation and service performance surrounding clinical healthcare under MAR. The guideline may be regarded as a procedural standard in which the recipient groups include the municipal employees within social services and the GPs. As such, these procedures seek to standardise the actual *content* of the work, which was formerly a matter left solely to the individual professional (Timmermans & Berg, 2003; Ramsdal & Fineide, 2010; Fineide, 2012).

Both the new regulations and the guidelines intend for MAR to undergo greater normalisation. MAR is to be offered following an individual professional assessment of the individual patient's condition and need for healthcare. The former scheme had an eligibility age-limit of 25 years, which has now been removed. The intention was also for MAR to be an equitable programme throughout Norway.

The aim of medication-assisted rehabilitation is for opioid abusers to improve their quality of life and to assist them in altering their life situation by improving their optimal mastery and functional levels. The object is also to reduce the harmful effects of opioid abuse and the risk of death from overdose (MAR regulations of 2010, Section 2).

Since 2004, there has been an almost explosive increase in the number of patients undergoing MAR. In an international context, Norway is among the countries with the highest coverage for substitution therapy in relation to the estimated number of opioid misusers (Skretten, 2011:151). With a net increase of just over 600 patients annually, the number of patients undergoing MAR doubled in the period 2004-2011. At year-end 2011, 6,640 patients were on an MAR programme. Up to 25% reported depression or anxiety, but only 12% were receiving psychiatric treatment, and only 9% were receiving systematic psychotherapy (Harr, 2012).

The aim is to achieve a tripartite collaboration between the specialist health service, and social and health services at municipal level. Social services and GPs have an independent right of referral to IST. Under the regulations, only approved centres, in this case SMP in practice, may assess who is eligible for MAR. This is also where the treatment must be based. However, it emerged that in many cases, GPs initiated substitution rehabilitation before the patient had been assessed by the specialist health service. 'The Norwegian Board of Health Supervision has regarded this as untenable practice unless it is part of a clearly defined phased withdrawal plan' (Guideline IS 1701, 2010:100). The present study has no data on whether such

practice is the case for the surveyed GPs. It might, however, serve to account for the fact that a majority of the GPs in our study convey that the regulations and the national guidelines are not readily available, comprehensible or workable. Another factor that may serve to account for the GPs' interpretation of these public policy instruments is to do with the fact that MAR practices are largely assigned to the GPs. This is borne out by the fact that a steadily increasing proportion of patients are prescribed the MAR medication by their GP. In 2010, this proportion was 68 per cent (Report to the Storting, no. 30, 2011-2012; 79) GPs as a professional group undoubtedly hold power as 'door-openers' (Molander & Terum, 2008) for initiating MAR. The study reveals that some of them hold that the specialist health service should take over medical responsibility entirely, releasing GPs from this work. This study does not address this issue; suffice to say that a statement of this nature suggests that the GPs feel that they are under pressure. It would seem as if they have acquired an unpleasant 'gatekeeper function' (Terum, 2003). In other words, there would seem to be poor correspondence between policy intentions (as laid down in public policy instruments) and practice in the field. This is particularly the case regarding which agents in practice appear to have principal responsibility for MAR.

Experiences of cooperation and competence requirements

As mentioned earlier, the basic organisational model for this form of rehabilitation is a tripartite cooperation between the municipality, GP and specialist health service. In the municipality we investigated, this is the model in operation. The specialist health service's IST programme is provided by the social medicine outpatients' clinic (SMP).

The two groups of employees in our study have different experiences of cooperation within the MAR system. Cooperation with the more technical and instrumental services performed by the on-call doctor and pharmacy are perceived as a boon for both parties.

But where arrangements are not explicit and the content more complex, perceptions of continuity are more divergent.

Any cooperative process has to be anchored. There are usually two factors that serve to create cooperative arenas (Knudsen, 2004). One factor is that the participants feel they have a need for such cooperation and that it will result in attainment of its intended aims. The second factor is that parties are ordered to cooperate, as in this case, by the policies concerning tripartite MAR cooperation. The study reveals that the municipal employees appear to maintain a culture of cooperation that means they get along well with their co-workers, the GPs and the specialist health service alike. The GPs value cooperation with municipal employees highly, but would seem to be affected by lesser cooperation amongst themselves and a somewhat ambivalent relationship with the specialist health service. This latter factor is commented on in the preceding section. The lack of cooperation between doctors is possibly

attributable to the regular-GP reform from 2001. Here, the doctors are self-employed, operating their own practice, and have few fora in which to meet.

The material in this study indicates that municipal employees represent a communal culture of cooperation and are accustomed to providing an integrated service in which suitable interventions in relation to the patient's/client's needs are arrived at through meetings and discussions. In this way, the employees base their practice on common professional ground, regardless of their differing professional affinities. The GPs seem to reflect a culture where each GP makes decisions single-handedly without consulting others. Although the GPs represent the same profession, a hectic working day with a large number of patients and earnings requirements will presumably have the effect of reinforcing this individualist culture. That said; the GPs refer more favourably to cooperation with municipal employees than the reverse. The municipal employees report that cooperation with the GPs is not as good as it could be, and that it is highly dependent on the individual GP concerned. One challenge in cooperative relationships is precisely this relationship between professions. An obvious approach to interpretation of these findings is thus to view them in the light of a professional perspective. There is much to indicate that the materials reflect a classic collision between the defining traits of two professions. The professions define their jurisdiction (Abbott, 1988) in relation to the different MAR tasks to be solved within the tripartite cooperation. One challenge associated with the professions is that there is usually a clear correlation between the treatment panorama of their domain and how they resolve the problems that present themselves (ibid). The GPs and the municipal employees represent different professional approaches in the working day. While the GPs represent tenets of medical science, the municipal employees employ tenets of social or psychosocial science. As a result, the two groups are not focusing on the same problems. Equally it is conceivable that a conflict might arise between professions as to what constitutes the problem and the appropriate response.

The two respondent groups provide differing responses when we ask them about the need for greater competence. The GPs convey a greater need for mapping tools, substance abuse information, legislation and methods for working with MAR patients than the municipal employees.

Here again, the professional perspective would appear to provide a useful interpretative framework. From the universities and university colleges system, we know that health and social workers have far greater emphasis on substance misuse and interdisciplinary studies than doctors in their initial degree programmes. These are also the groups who tend to take more comprehensive courses of higher education, while doctors tend more often to take shorter post-professional education courses restricted to their own profession. The responses indicate that the entire professional field surrounding MAR patients is better geared to professionals with a more psychosocial perspective than to those with a more narrowly medical perspective.

Concluding comments

The survey discussed in this article represents the first study of the experiences of two important professional groups regarding a new regime for medication-assisted rehabilitation of substance abusers in Norway.

Although limited in scope and depth, the study raises a number of issues and likely interpretations which merit attention in the professional field. Further research based on this survey should be able to trace the evolution of current practices and increase generalisability by extending the number of informants in the professional group and by including the MAR users' own experiences of current practices.

References

- Abbott, A. (1988) *The system of Professions: An essay on the division of expert labor*. Chicago: University of Chicago Press
- Bramness J.G., Clausen, T., Ravndal, E. and Waal, H. (2012) *LAR-forskning 2011*. SERAF Rapport 2/2012. University of Oslo, Department of Clinical Medicine
- Brekke, M., Vetlesen, A., Høiby, L., and Skeie, I. (2010) Livskvalitet hos pasienter i legemiddelassistert rehabilitering. *Tidsskrift for Den norske legeforening*, 130, 1340-1342
- Brinkmann, S. (Ed.) (2012) *Det diagnosticerende liv. Sykdom uten grenser*. Århus: Forlaget Klim
- Courtwright, D. T., (1997) The prepared mind: Marie Nyswander, methadone maintenance, and the metabolic theory of addiction, *Addiction*, 92, 257–266
- Dole, V. P. and Nyswander, M E. (1965) A medical treatment for diacetylmorphine (heroin) addiction. *Journal of American Medical Association*, 193, 80-84
- Fineide, M. J., (2012) *Controlled by knowledge: a study of two clinical pathways in mental healthcare*. Karlstad University studies 2012:19. Karlstad: Karlstad University Press
- Frank, V. A. and Bjerger, B. (2011) Empowerment in drug treatment: Dilemmas in implementing policy in welfare institutions. *Social Science and Medicine*, 73,; 201-208
- Goffman, E., (1963) *Stigma. Notes on the Management of Spoiled Identity*. Englewood Cliffs: Prentice-Hall
- Haasen, C., U. Verthein, P. Degkwitz, J. Berger, M. Krausz and D. Naber, (2007) Heroin-assisted treatment for opioid dependence. *British Journal of Psychiatry*, 191: 55-62
- Norwegian Directorate of Health (2010) *Nasjonal retningslinje for legemiddelassistert rehabilitering ved opioid avhengighet*. Oslo: Helsedirektoratet, IS-1701
- Norwegian Ministry of Health and Care Services (2004) *Rusreformen- pasientrettigheter og endringer i spesialisthelsetjenesteloven*. I-8/2004. Oslo
- Hogg, M. A. and G. M. Vaughan, (2011) *Social psychology*. Harlow: Pearson
- Johannessen, A., P. Tufte and Line Kristoffersen, (2004) *Introduksjon til samfunnsvitenskapelig metode*. Oslo: Abstrakt Forlag
- Knudsen, H. (2004) Samarbeid på tvers av organisasjonsgrenser. in Repstad, P. (Ed.)

- Dugnadsånd og forsvarsverker*, Oslo: Tano
- Forskrift om legemiddelassistert rehabilitering (LAR-forskriften) FOR-2009-12-18-1641 LAR forskriften av 2010*
- Lascoumes, P. L., and Le Gales, P. (2007) Introduction: Understanding Public Policy through its Instruments - From the Nature of Instruments to the Sociology of Public Policy Instrumentation. *Governance*, 20, 1-21
- Lund, I.O., Skurtveit, S. Engeland, A. Furu, K. and Handal, M. (2012) Prescription drug use among pregnant women in Opioid Maintenance Treatment. *Addiction*, 108: 367-376
- Molander, A. and Terum, L.I. (2008) Profesjonsstudier: en introduksjon. In *Profesjonsstudier: en introduksjon*. Oslo: Abstrakt
- Nygård, R., (2007) *Aktør eller brikke?: Søkelys på menneskets selvforståelse*. Oslo: Cappelen
- Ot.prp nr. 54 (2002-2003) *Om lov om endringer i lov 13. desember 1991 nr. 81 om sosiale tjenester m.v. (Rusreform II and rett til individuell plan)*
- Ot.prp. nr 66 (2000-2001) *Om lov om helseforetak m.m. (helseforetaksloven)*
- Pettersen, K. T. (2009) *An Exploration into the Concept and Phenomenon of Shame within the Context of Child Sexual Abuse*. Doctoral thesis 2009: 184. Trondheim: Norwegian University of Science and Technology
- Pettersen, K.T. (2013) Working with dignity: A study of the work done within Norwegian incest centres. *Social Work and Social Sciences Review* 16, 101-112
- Ramsdal H. and Fineide M. J., (2010) *Clinical Pathways as a Regulatory Tool in Mental Health Policies. A report on regulations in Health Policies in Norway* . www.knowandpol.eu
- Salamon L.M. and Elliott, O.V. (2002) *The Tools of Government: A Guide to the New Governance*. Oxford: Oxford University Press
- Skretting, A. and Storvoll, E.E. (Eds.), (2011) *Utviklingstrekk på rusmiddelfeltet. Grunnlagsmateriale til regjeringens stortingsmelding om rusmiddelpolitikken*. Oslo: SIRUS-Rapport 3/2011
- St. Melding nr. 30 (2011-2012) *Utdanning for velferd - Samspill i praksis*
- Stubberud, J., Åsland, R. and Kristensen, Ø (2007) Hvorfor mislykkes behandlingen? En undersøkelse av kognitiv funksjon og personlighet hos pasienter i legemiddelassistert rehabilitering. *Tidsskrift for Norsk Psykologforening*, 8, 1012-1018
- Terum, L.I. (2003) *Portvakt i velferdsstaten. Om skjønn og beslutninger i sosialtjenesten*. Oslo: Kommuneforlaget
- Timmermans, S. and Berg, M. (2003) *The Gold Standard: The challenge of evidence-based medicine and standardization in health Care*. Philadelphia, Pa.: Temple University Press
- Waal, H., Brekke, M., Clausen, T., Lindbæk, M., Rosta, J. Skeie, I., and Aasland, O.G. (2012) Fastlegers syn på legemiddelassistert rehabilitering. *Tidsskrift for Den norske legeforening*, 132, 1861-1866
- Wolfensberger, W., (1972) *The Principle of Normalization in Human Services*. Toronto: National Institute on Mental Retardation.