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A Preventive Ethics Approach to Methadone Maintenance Programmes

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Abstract

In New Zealand opioid users obtain their drugs by extraction from codeine-based products, prescribed medication and poppies (in season) as geographical isolation and efficient border protection mean that street heroin is expensive and irregularly available. Hospital run methadone programmes have a virtual monopoly on the provision of opioid substitution programmes leaving clients with limited options if they want to leave methadone programmes. This leads to high client retention rates and provides an opportunity to explore the characteristic conflict that occurs between clients and providers of these programmes.

Methadone providers are open to charges of paternalism as they exercise power in what they perceive as the best interests of their clients. Paternalism can be justifiable in treatment where a patient faces serious risks that can be reliably predicted, where these risks are irreversible and where patients have impairment in their autonomy. There may be a degree of impaired autonomy in clients entering a Methadone Maintenance Programme (MMP) as a product of the desperate circumstances of clients on entry to the programme and as a result of opioid dependency. However the risks of not participating in the programme cannot be reliably predicted for an individual client and the impairment in autonomy is of a temporary nature, making paternalism unjustifiable in these programmes.

It is suggested that paternalism may be more than a perception in methadone programmes and that it may contribute to conflict between providers and clients. Aspects of MMPs that may indicate paternalism are: confusion between the long term and short-term aims of the programmes, assumptions regarding client autonomy on entry and after clients stabilise on the programme, confusion over the application of harm minimisation aims and the inflexibility and social invasiveness of programmes.

Preventative ethics is a process whereby programme structures are examined to identify and eliminate those which may lead to unacceptable treatment for clients. This paper examines aspects of MMPs that have the appearance of paternalism and suggests a number of programme design strategies that might assist in eliminating unjustifiable paternalism from MMPs.

Introduction

Methadone Maintenance Programmes (MMPs) began in the US in the 1960's (Dole and Nyswander, 1965). They involve the substitution of a prescribed opiate for illegally obtained (street) drugs as a treatment for clients with an established history of opioid dependence. Initially MMPs sought to stabilise opioid clients and then withdraw the opioids with slow reductions in dose (Dole and Nyswander, 1976; Sellman, *et al* 1996). However, as even stable clients once withdrawn from methadone have a high rate of return to illicit opioid use and as the long term use of methadone is relatively safe for the client, methadone treatment is now regarded as a long-term treatment, potentially but rarely lifelong (National Protocol for Methadone Treatment in New Zealand, 1996, s17).

The programmes are offered via a wide range of local protocols that include a greater or lesser degree of client monitoring by medical staff, counsellors and pharmacists and through urine drug screens. Monitoring is an attempt to check that methadone is taken as prescribed not sold or accumulated and to measure opiate and other drug use. Protocols range from very controlling with daily pick up of methadone and frequent monitoring of urine samples to protocols which allow clients to pick up many doses at a time without supervision and little monitoring of urine.

The degree of control incorporated into methadone programmes presents a particular difficulty to the opioid addicted client group who are more likely than the general population to have multiple psychological disorders including a significant level of cluster B personality disorders, particularly Antisocial Personality Disorder.

Methadone programmes in New Zealand have high client retention rates given the client group. Hospital run MMPs have a monopoly on the provision of this treatment and as a remote island nation with relatively secure borders New Zealand has a sporadic supply of imported opioids such as heroin. The relative scarcity of street opioids keeps their price high and this in turn contributes to a high retention rate in methadone programmes, (e.g. the Nelson programme had a 92% retention rate in methadone clients over the year 1/7/99-31/6/00).

Conflict between providers and clients was observed from the inception of MMPs (Dole and Nyswander, 1965). The long-term nature of the programmes and the high retention rate in New Zealand programmes provides an opportunity to observe and understand this conflict.

The widespread presence of conflict between providers and clients of MMPs would be expected to bring the programmes under intense scrutiny to determine whether programme structure contributes to this conflict. However despite the forty-year history and extensive literature on methadone maintenance there is a dearth of literature examining MMPs from an ethical perspective.

Consumer groups have attributed the conflict between providers and clients in MMPs to paternalism on the part of providers (Mainline, 1998). Paternalism is the unbridled use of beneficence based clinical judgements. Beneficence is the ethical principle obligating health providers to seek a greater balance of benefits over costs or harms for the client (Engelhardt and Coverdale, 1993). Paternalism is justifiable where a broad view of the costs and benefits of a treatment programme indicates an advantage to the client of sufficient power to annul the client's rights under the principles of natural justice to the assumption of autonomy.

The benefits of MMPs have been well established and include the minimising of the harms that result from street use of opioids and particularly from intravenous (IV) use. These harms include the dangers of blood borne viral infection, particularly Hepatitis B and C and Human Immunodeficiency Virus, the specific health risks associated with poor IV technique, the chronic health effects caused by the impurities injected with opioids (Ward, Mattick and Hall, 1998) and death or more commonly acquired cognitive impairment from overdose (Mintzer and Stitzer, 2001). In addition the MMP frees the client from the need to locate opioids on a daily basis and find the money to pay for them. Drug seeking and funding behaviour is extremely time consuming for an addict and may constitute the principal harm associated with street use of non-prescribed opioids. Funding drug use frequently requires criminal behaviour with one NZ study estimating the direct costs of crime committed by opioid addicts on MMP waiting

lists at $2,477 per addict per week (Adamson and Sellman, 1998).

Consumption of a consistent dose of methadone on a daily basis is associated with minimal physiological risks for the client providing no other drugs are used. While not a risk, a cost to the client in an MMP are the monitoring requirements designed to ensure that the methadone is used as intended. This results in restrictions on clients that consumer groups have likened to chemical handcuffing (Mainline, 1998). These restrictions are justified on the basis of ensuring the safety of the clients and minimising diversion of methadone for sale in the illicit drug using community (Fisher and Rehm, 1997 and Neelman and Farrell, 1997). However from the client's perspective these restrictions are a burden exacerbated by the long-term nature of the treatment.

It might be argued that there is a place for paternalism at the time a client enters an MMP as at this time the benefits of the programme clearly exceed the risks. However this argument fails, as the risks of not entering an MMP are neither reliably predictable nor wholly secondary to illicit opiate use as opposed to other associated disorders, e.g. Antisocial Personality Disorder. In any case this kind of paternalism would lead to clients being strongly encouraged to enter the MMP, which is not how paternalism is found in an MMP. Paternalism is apparent in an MMP in a lack of a distinction between the MMP's long and short-term aims, the assumptions about autonomy and informed consent when clients enter a programme, confusion regarding the harm minimisation philosophy of programmes and the degree of invasiveness of programmes. Each of these areas is examined separately.

Long and Short Term Aims

An MMP has distinct long and short-term aims. The short-term aims are to do with the reduction of immediate risks associated with exposure to street opioid use i.e. risks associated with overdose and drug impurities and IV administration. These aims are achieved primarily through the pharmacological effects of methadone.

The long-term aims are to do with the reduction of chronic harms. That is a reduction of other drugs use, the fostering of safer lifestyle choices and a less pathological participation in the community. The long-term aim of an MMP is to capitalise on the short-term benefits of the programmes and make more fundamental lifestyle changes possible for clients. However providers of programmes routinely assume that the prospective client is giving consent to both sets of aims on entering treatment; i.e. consenting to the aims regarding major lifestyle change or chronic benefits as well as the short-term aims of meeting acute needs. This leads to confusion and even conflict over what clients have consented to on entering the programme, raising serious issues over the process of informed consent on entry into an MMP.

Client Autonomy and Informed Consent on Entry into Programmes

Paternalism may be found in the assumptions about autonomy and effective informed consent when clients enter a programme. Informed consent to treatment requires disclosure on the part of the provider and decision-making capacity or autonomy plus voluntariness on the part of the client.

Providers may not be accused of keeping clients ignorant of the programme's parameters. Typically as part of induction into a programme the client will be informed of the rules under which the programme operates. This information and the consequences of transgressions of clinic rules will typically be given to clients in both written and oral form and can occupy as much as fifteen typed pages. Clients may have already had an information booklet on methadone maintenance, which can be equally voluminous (Kemp, 1999).

The detailed disclosures by providers do not focus on the costs and benefits of the MMP, rather they are designed to pre-empt problems with compliance with the programme rules in the future. Clients are held to the requirements of the treatment programme on the basis that they have agreed to a treatment contract that included these conditions. These efforts at disclosure both arise from and contribute to a more fundamental problem. That is that at the point of entry into the programme clients have impaired autonomy induced by the desperation of their circumstances.

Many opioid addicted clients in acute chaos would sign virtually anything in order to receive methadone. Their desperation arises from the chaotic life style that is part of addiction to an illegal (expensive) drug and a need to avoid an unpleasant withdrawal syndrome (Ward, Hall and Mattick, 1999). In this regard their desperation is more pronounced than is usual for clients consenting to other medical procedures. Clients are best thought of as entering the MMP with the aim of changing the source of supply of their drug rather than their drug use. That is, clients share the acute needs aims of an MMP on entry to it but a presumption that they have given informed consent to the programme's long term aims is at best a misunderstanding and at worst an abuse of the programme provider's power over a very vulnerable client.

Harm Minimization Versus Harm Elimination

The appearance of paternalism can arise from confusion between the philosophies of harm minimization and harm elimination in programmes. Providers of an MMP are likely to espouse values of harm minimization (also known as harm reduction (Dole and Nyswander, 1976)). In a harm minimization programme success is defined as the client moving towards reduced harm on a continuum of harms or risk-taking behaviours. A continuum of harms for illicit opioid use would have at its most harmful end a constellation of very high-risk behaviours for the client and the community, for example the injection of street opioids obtained through violent crime with shared equipment into veins in the neck. The least harmful end of this continuum might be abstinence from drugs.

Though the rhetoric of providers is for harm reduction there is evidence that the attitudes of front-line staff are closer to harm elimination. Caplehorn, Lumley and Irwig (1998) found in Australia (no comparable data are available for NZ) that although senior staff of an MMP tended to reject abstinence oriented policies, the staff with the most contact with clients, that is nurses and counsellors, tended to have an abstinence orientation. This is manifest in the restrictions put on clients, which clients generally perceive as punishments for transgressions of programme rules, especially where these restrictions are a reaction to the recreational use of drugs with little if any capacity to contribute to overdose in combination with methadone such as cannabis. These restrictions amount to prescribed methadone being provided in return for eliminating the use of other drugs by clients. This represents a significant departure from the National Protocol for Methadone Treatment in New Zealand (1996), which does not mention eliminating other drug use amongst the objectives for methadone treatment.

It is doubtful whether clients share the treatment aim of harm elimination. This aim may be based on a paternalistic belief on the part of providers and the community that the elimination of all drugs (other than methadone) would be in the client's best interest. However where providers attempt to run a methadone plus no other drugs programme they are no longer offering an evidence based treatment as the benefits of an MMP have been established for the treatment of opiate addiction only, not for all addictions. In addition a harm elimination programme is seeking to achieve drug abstinence with a group of clients who by definition are strongly drug oriented. Unless these clients are fully supportive of the 'methadone and no other drugs regime' it is likely to fail.

This mismatch of goals between clients, providers and the protocol can lead to a punitive urine-monitoring programme. Urine samples are tested not just for the presence of methadone and drugs that can potentially lead to overdose in combination with methadone, but also for all the common drugs of abuse. Where other drugs are found, clients lose privileges on the programme. These are often loss of access to take-away doses but in extreme cases can be exclusion from the programme (National Protocol for Methadone Treatment in New Zealand, 1996).

Making client privileges contingent on the elimination of all other drug use as verified by the results of urine drug screens is a direct result of inconsistently applying a harm minimisation treatment model on a paternalistic basis. This discourages clients from discussing their drug use with counsellors and is likely to detract from treatment success. In as much as the harm elimination objectives of MMPs are paternalistically based they exacerbate the power imbalance between clients and providers and increase levels of conflict in MMPs.

The Invasiveness of MMPs

Paternalism is apparent in the degree of invasiveness of MMPs in the lives of clients. The long-term nature of the programme and the client's addiction to methadone make it difficult for the client to conform to the requirements of programmes. All normal activities of daily life such as working, taking a holiday, attending family events, marriages, funerals etc., have to be fitted in around the requirements of the programme. Clients report they find the requirements of an MMP onerous and invasive (Mainline, 1998).

The client's lack of charity regarding the programme rules may have its roots in the widespread belief amongst clients that these restrictions are for the benefit of the community rather for them. In fact the situation is less clear-cut than this as there is evidence suggesting that when methadone is prescribed on a laissez-faire basis deaths from opioid overdose increase (this mortality rate is still lower than for untreated clients), (Sweensen, 1988).

Paternalism in MMPs

Client factors certainly contribute to conflict in MMPs however it is clear that so does paternalism. Providers who accept high levels of conflict by attributing it to a difficult patient group may be in denial of the programme's contribution to conflict. Paternalism is likely to contribute to conflict and the possibility of paternalism must exist in any programme which has confused aims regarding harm minimisation, is highly invasive and inflexible, fails to distinguish between its long and short term aims, fails to recognise a probable impairment in the client's autonomy and fails to recognise when the client's autonomy is no longer impaired.

In any case if the client group by virtue of a high rate of personality disorder has characteristics contributing to conflict this needs to be addressed in the programme design and the onus is on the programme providers to do this.

Strategies for Designing Programmes to Reduce Paternalism

The confusion regarding harm minimization and harm elimination could be reduced by more clarity on the part of programmes perhaps achieved via more client representation in the development and monitoring of programmes.

The direct connection between results from urine screens and granting programme privileges may be an abdication by providers of the responsibility for making comprehensive clinical judgments. Decisions about privileges, which amount to decisions about the degree of invasiveness of monitoring should be based on judgements of client safety rather than arbitrary rules, over reliance on urine drug screen results or simply in the interest of consistently following programme rules.

Providers need to distinguish between the acute needs aims and chronic benefits of an MMP and to limit agreements from clients entering the programme to agreement to the acute needs aims. This would require a change in the structure of MMPs that could be achieved by starting clients on a safe therapeutic dose of methadone with little monitoring and no take-away doses. This would meet the acute needs aims of a methadone programme. Once clients were on this programme they could be offered access to a programme that addressed the chronic benefits aims of a methadone programme without any connotation of a paternalistic abuse of power, as clients would be free to accept or reject this offer without being desperate to get onto a programme.

Informed consent on entry into the programme needs to be confined to issues specifically regarding the acute aims of the programme and not be used as a means of pre-empting disputes regarding the chronic aims of the programme that may arise later.

Programmes could productively change their model of informed consent towards regarding informed consent as a process rather than an event (Lidz, Appelbaum and Meisel, 1988). This makes informed consent an ongoing aspect of a treatment partnership rather than having the qualities of an enforceable agreement frozen in time.

Finally paternalism may be part of the reason why the dissatisfaction of clients, often manifest through conflict has

resulted in minimal changes in MMPs. That is complaints are seen as characteristic of methadone clients and methadone/opiate addicted clients are seen as difficult rather than as clients with multiple disorders (Regier, Farmer and Rae, 1994). Programme providers must ensure that the dual diagnosis nature of the methadone client group remains paramount in their attitude to clients and work towards achieving a therapeutic partnership with clients (Townshend, 1998). A partnership model would be characterised by staff and clients jointly setting goals for treatment rather than persisting with inflexible goals defined by state or national protocols.

Summary

There is potential for MMP providers to behave paternalistically as there are elements of social control and significant power discrepancies between providers and clients in an MMP. The MMP provider is the controller of a drug that the client is utterly dependent on and cannot obtain from an alternative legal source.

Typically clients and providers perceive their power relationship differently (Stent and Townshend, 1999). Providers see power being used in the best interest of the client while clients feel that the treatment is paternalistic. The client's sense of power discrepancy and paternalism may be heightened by the nature of drug use. For most of the population and for MMP clients with respect to their other and previous drug use, drug use is an individual lifestyle choice.

Regardless of perspective, when health providers make decisions which have a profound impact on their clients' lifestyle and do so from a position of considerable power they must be scrupulous in their ethical standards and particularly vigilant regarding paternalism in their treatment policies and practices.

References

Adamson, S. and Sellman, J. (1998). The pattern of intravenous drug use and associated criminal activity in clients on a methadone treatment waiting list. *Drug and Alcohol Review* 17: pp. 159-166

Caplehorn, J., Lumley, T. and Irwig, L. (1998). Staff attitudes and retention of patients in methadone maintenance programs. *Drug and Alcohol Dependence* 52(1): pp.57-61

Dole, V. and Nyswander, M. (1965). A medical treatment for diacetylmorphine (heroin) addiction. *Journal of the American Medical Association.* 193:pp.646-650

Dole, V. and Nyswander, M. (1976). Methadone maintenance treatment: A ten-year perspective. *Journal of the American Medical Association* 235: pp.2117-2119

Engelhardt, H. and Coverdale, J. (1993). The psychiatric admission index: Deciding when to admit a client. *The Journal of Clinical Ethics* 4: pp.315-318

Kemp, R. (ed) (1999). *New Zealand Methadone Handbook.* Wellington: Robert Kemp

Fisher, B. and Rehm, J. (1997). The case of a heroin substitution treatment trial in Canada. *Canadian Journal of Public Health.* 88: pp.367-370

Lidz, C., Appelbaum, P. and Meisel, J. (1988). Two Models of Implementing Informed Consent. *Archives of Internal Medicine.* 148: pp.1385-89

Mainline Editorial (1998). January. *Liquid Handcuffs and Chemical Truncheons?* Christchurch NZ: The Roger Wright Centre

Mintzer, M. and Stitzer, M. (2001). Cognitive Impairment in Methadone-Maintained Long-Term Poly-Drug Abusers, *Drug and Alcohol Dependence* 63, Supplement 1: pp.107

Moss, A., Vranizan, K. and Gorter, R. *et al.* (1994). HIV seroconversion intravenous drug users in San Francisco 1985-1990. *AIDS* 8: pp.223-31

National Protocol for Methadone for Methadone treatment in New Zealand (1996). 4th Edition. Ministry of Health NZ May

Neelman, J. and Farrell, M. (1997). Fatal methadone and heroin overdoses: Time trends in England and Wales. *Journal of Epidemiology and Community Health.* 51: pp.435-437

Regier, D., Farmer, M. and Rae, D. *et al.* (1994). Co morbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) study. *Journal of the American Medical Association* 264: pp.2511-16

Sellman JD., Hannifin J. Deering D. and Borren P. (1996). *Delivery of treatment for people with opioid dependence in New Zealand: Options and recommendations.* A paper commissioned by the Ministry of Health, New Zealand.

Sweensen G. (1988). Opioid drug deaths in Western Australia 1974-1978. *Australian Drug and Alcohol Review* 7: pp.181-185

Townshend, P. (1998). The Cartwright Report ten years on: The obligations and rights of health consumers and providers. *New Zealand Medical Journal* 111: pp.390-393

Stent, R. and Townshend, P. (1999). The Health and Disability Commissioner Act. *New Zealand Medical Journal* 112: pp.56-7

Ward, J., Hall, W. and Mattick, R. (1999). Role of maintenance treatment in opioid dependence. *The Lancet* Vol 353 Jan 16

Ward, J., Mattick, R. and Hall W. (eds). (1998). Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic, 1998

Ward, J., Mattick, R., Hall, W. and Darke, S. (1996). The effectiveness and safety of methadone maintenance. *Addiction* 91(11): pp.1727-1729

Wolf, K., Hay, A., Harrison, K. and Raistrick. D. (1996). Non-prescribed drug use during Methadone treatment by clinic and community based clients. *Addiction* 91 (11): pp.1699-1704

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