

response

Appropriateness Versus Practicality of MMT

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Thomas De Quincey (1785-1859) felt drug taking was a 'default' activity; that there was nothing else better to do. Most drug takers would say they take drugs for pleasure — willingly embracing a temporary state of inauthenticity. Others might say that drug taking is a means to feel different, to cope with distress (and withdrawal) or enhance an activity. There are many reasons for the individual to partake in drug use. The point at which drug taking becomes problematic is difficult to define and depends on the context and boundaries of drug use, let alone other aspects relating to the vulnerability of the individual and the nature of the drug. In other words addiction has many threads, which when intertwined make a strong attachment with the preferred drug. Kermack makes a brave attempt to unravel the processes and theoretical paradigms involved in addiction. On the other hand policy makers tend to grab hold of one of the threads and elevate its importance above all others. For example in 1995 the National Institute of Health in the US declared that addiction is a 'brain disorder', thus firmly placing addiction within the bounds of the disease model. Whilst the intentions of this powerful body were noble — an attempt to destigmatise addiction (and to gain political and economic leverage) — it is misguided and a gross simplification of this phenomenon. It is also difficult to reconcile this paradigm when there is a concurrent 'war on drugs' which takes a highly moralistic viewpoint, punishing those who use drugs rather than treating them.

Dole and Nyswander (1965) took a more pragmatic approach and regarded methadone programmes as a medical treatment and helped to establish that the benefits of the treatment outweighed the possible disadvantages in the majority of those patients treated in this way. This revolutionary treatment coupled with the abject failure of prohibition flew in the face of the prevailing moral attitude

to the use of 'addictive' drugs. It was not until the onset HIV/AIDS that the treatment started to become accepted at a political and health provider level as a device to lessen the potential explosion of this disease which threatened the well being of the community. In this sense the priority was to lessen the IV route and sharing of needles/ paraphernalia (especially heroin and other opioids), which is the main mode of transmission of this disease.

The concept of harm minimization acknowledges that the ultimate goal of abstinence is not realistically achievable in the majority of drug users, at least in the short term. It also embraces a hierarchy of achievable goals in which treatment (methadone programmes) are only a component but also attempts to balance the conflicts between the harm to the individual versus the wider public.

MMT (methadone maintenance treatment) programmes are certainly not a panacea or cure for opioid addiction. Viewed as a treatment, decisions have to be made as to whether MMT is likely to be beneficial to the opioid dependent individual and to consider whether side-effects of the treatment (e.g. the effect of diversion of methadone on society) do not out-weigh the therapeutic effects. MMT may not be appropriate treatment for all opioid dependent individuals — as with most treatments. An analogy might be with the treatment of depression, where anti-depressant medication is at best effective only in approximately 70% of those people suffering from the disorder and alternative treatments are required for the rest. It could be argued that a primary goal of MMT is to eliminate IV use and the use of investigations such as needle mark checks and urine tests are merely a means to help a clinical decision and determine if this goal is being met. As pointed out in the articles MMT also serves as an entry for opioid dependent persons to

address medical and social problems which are more prevalent in this population compared to the general public.

Determining the balance regarding the accessibility and acceptability of MMT is beset with debate and controversy. Townshend *et al.* give some suggestions regarding the ethics of consent to short and long term goals of MMT. Taking these suggestion further one solution to this dilemma might be to adopt a different methodology for execution of MMT. This might be as follows: all opioid dependent clients consent to and enter a 'low-threshold' methadone programme which has easy access, a low regulatory stance (no urine tests), a fixed dose of methadone, fixed daily consumption of methadone and low clinic intervention. It is likely that a proportion of consumers would prefer to stay on this programme whilst the majority would consent to enter a more comprehensive and regulated programme complete with individualised dosing, access to support and specialist services. Essentially the low threshold programme would be a prelude to entry into the 'high-end' programme — typical of current MMT programmes in New Zealand.

There is some evidence that a low threshold approach has a number of beneficial effects for the individual and society (Yancovitz, 1991; Dole, 1991) and elements of this are utilised in other countries, notably Holland. The low-threshold programme has a more community focus and addresses some of the immediate needs of the user, that is a safe, secure supply of opioids, and would be a low resource intensive (cheaper) programme. The more regulated 'high-end' programme accepts a more paternalistic stance and focuses on maximising the therapeutic benefits of methadone with treatment aims such as increasing health and decreasing crime, pathological socialisation, IV use and other drug use. This would also have the effect of abolishing the waiting list and address some of the conflicts between the consumers and the clinic as well as satisfying the difficulties with consent.

The Ministry of Health (MoH) rations the access to MMT despite the overwhelming evidence of the cost benefit of this treatment modality (Barnett, 2000). However, there is a stated agenda to start to move the treatment from specialist services to primary care. This currently occurs by a process

of authorising GPs from the specialist clinic or in some cases having GPs gazetted through the MoH to prescribe methadone for dependence. In the latter the GP becomes an autonomous treater of opioid dependency and therefore the specialist clinics do not hold a monopoly. The concept of shared care (similar for diabetes or obstetrics) can be entered into with the specialist clinics.

Ball and Ross (1991, p.248) point out that positive attitudes from treating staff are an essential component of an effective MMT. The conflict between harm minimization and harm elimination can create confusion and dissatisfaction for the consumers and clinic staff alike. I agree that there is little or no evidence to suggest that cannabis smoking impinges on methadone use but the same can not be said for the use of other drugs. Benzodiazepines, for example, have a strong association with significant morbidity and mortality when taken in conjunction with methadone and hence may be seen as contraindicated and a cause for safety concern when concomitantly taking methadone. Likewise urine tests revealing the concomitant use of other opioids may simply mean that the methadone is not optimised for the individual and opioid blockade has not been reached or that continued IV drug use undermines the major public health benefit of MMT.

MMT programmes do not exist in a vacuum and are under pressure from competing demands of society and the needs of opioid dependent users. Whilst alcohol drinking and tobacco smoking are accepted as a social norm there remains a great deal of stigma relating to other drug use. Evidence reveals that employers are more sympathetic to alcoholics than to stabilised methadone users (Joseph, 2000). As Kermack points out the (often unspoken) prevailing attitude of the public is to adopt a moral stance to drug users, that the individuals concerned are morally bankrupt and deserve punishment rather than treatment. Even amongst the medical profession there is ignorance and a moralising stance to drug users (even stable individuals in a MMT programme) with a common belief that addiction is not a legitimate area for doctors (Cooper, 1992). From a clinic point of view it can be difficult to walk the swaying tightrope which spans the great divide between committed drug user and the moralising public and media.

The concept of harm minimization and its practical application to the area of drug misuse continues to develop and evolve. These papers address important areas in the controversy and debate surrounding the implementation of MMT programmes in New Zealand. Determining the balance between addressing the needs and desires of the individual within an MMT and potential societal harms is difficult — there is great variation, even in New Zealand. Further debate and research through critical ethical analysis is a valuable tool to determine where the fulcrum lies at a particular point in time and place. Other areas worthy of continued debate might examine the goal of normalising the opioid dependent individual versus the constraints and regulatory nature of the methadone clinic, for example, the conflict between clinic attendance and employment. Certainly, the eyes and ears of those interested in addiction are upon the results of the Swiss heroin trials where the boundaries of the applicability of harm minimization are being tested, which in itself will raise a number of ethical issues.

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