response

Competing Ideologies in Substance Abuse Treatment

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Introduction

Life is difficult. At times, it is even painful, both physically and psychologically. In response, all cultures develop a variety of activities and chemicals to soften the hard edges of existence. It may be hard to differentiate between judicious use of chemicals for this purpose and their abuse; such interpretations will vary, depending on prevailing social mores and legislation.

Nevertheless, it is commonly agreed that substance abuse is an increasing problem in New Zealand. The spectrum here includes wide recreational use of marijuana, low heroin use compared to inner city use in Australia, a local propensity for 'home-bake', and prescription diversion of drugs such as MST (morphine slow release tablets) and Ritalin for intravenous use. There are an estimated 30,000 IV drug users in New Zealand, a small figure perhaps, compared to 800,000 in the US (Ciment, 1998), but still representing a significant problem for this country.

Two articles in this Journal of Bioethics have given good outlines of the background of substance abuse in New Zealand, focusing on ethical issues in the delivery of one particular treatment modality, that of methadone maintenance programmes for dependent opiod users seeking help (Towshend *et al.*, 2001, and Kermack, 2001).

This essay will briefly review those articles, and bring in other considerations with respect to this society's response to substance abuse. These other considerations include general practitioners' perspectives, drug diversion, experiences of 'recovered' addicts, and the AA model. The underlying premise is that how health professionals respond to drug users will reflect their subjective interpretation of drug using behaviour, and that current trends in the literature reflect the ebb and flow of society's attitude to chemical use.

Article Review

Kermack (2001) differentiated between three main models of addiction; the 'moral' model; the disease or medical model; and the 'maladaptive behaviour' or social model. The moral model attributes addiction to wilful misconduct, meriting treatment with punishment, while the other models ascribe less volition to the addicted person, whose behaviour is more determined by inherited genetic factors and/or social conditions. At one end of the spectrum, drug use is considered a crime and treatment programmes will insist on the goal of abstinence, while at the other end the 'harm reduction' model attempts to reduce secondary problems such as infection (HIV and Hepatitis C), crime and prostitution. An exemplar of a harm reduction model would be the methadone maintenance model for dependent IV users, where methadone is substituted for street supply of narcotics.

The rest of Kermack's article seemed to be an attempt to tease out any attitudes on the part of health care providers in a methadone programme that reflected an underlying moral model, so that 'Only when we absolve this tendency can we begin to optimise the efficacy of the strategies we employ to treat addiction'. In other words, a pure harm reduction policy needs to be unshackled from any judgement of the patient's volition, as 'not only is abstinence an impossible ideal, [but] policies aimed at achieving this ideal have been shown to actually perpetuate criminal activity in society'. (The back-up reference for this strong statement apparently being Wagstaff, 1989.)

To summarise the dualistic tension throughout the article, some of the word-clusters associated with the moral model were: abstinence as goal, repressive policies, stringent government restrictions, perpetuation of crime, moral reprehension of chemical consumption for pleasure,

counter-productive. By contrast, the word-clusters around methadone seemed to be: harm minimisation, crime reduction, life-style adjustment, positive integration, normalisation, strengthening of the will, sustained benefits, and so on, all very positive interpretations.

Townshend *et al.* (2001) on the other hand, used different terminology and ethical terms, but seemed to arrive at substantially the same point. In this paper, a similar dualistic comparison was between providers who espoused harm minimisation versus those in favour of harm *elimination*, this latter term being perhaps a euphemism for drug elimination or perhaps the (eventual) goal of abstinence. Attitudes on the part of staff indicative of this were labelled as 'paternalistic'.

> Although senior staff [of a methadone programme] tended to reject abstinence orientated policies, the staff with most contact with clients, that is nurses and counsellors, tended to have an abstinence orientation.

This led to some useful points, such as better informed consent and differentiating the short from the long term goals of the programme.

However overall, the paper was chillingly narrow in its ideology, implying that health care workers who deviate from clinic policy can be identified, labelled as paternalistic, and brought back to the fold of the true harm reduction model, once more unfettered by the contaminating and obstructive moral ideal that abstinence could be a possible long term goal in those desperate to seek help for their problems with addiction. Furthermore, the reason why an abstinence goal was labelled as 'paternalistic' was not clear, as any mismatch between client and provider could be similarly labelled. As well, one could argue just as readily that a blanket harm reduction goal is equally as disrespectful and paternalistic, and that limiting of goals could become a self-fulfilling prophecy.

In summary, the authors seemed to be appropriating a number of current ethical terms as a method of justifying their prior point of view.

The General Practice Perspective

There are a number of other perspectives on substance abuse treatment that are missing in the above two articles. Working as a GP provides one with many opportunities for interacting with substance users in all stages of addiction, but until recently medical training in addiction studies has been fairly poor. In general, doctors have lacked good skills in substance use, such as differentiating between abuse and dependence, being able to do a brief alcohol intervention, or even being able to take a full alcohol history. It is only recently, as well, that gambling addiction has been identified as a significant cause of social morbidity and that GPs are in a good position to make a primary assessment (Sullivan *et al.*, 2000).

Perhaps as part of this lack of training, many GPs have become understandably cynical about their effectiveness with drug and alcohol users. In addition, most GPs have been 'conned' at some point by drug-seeking patients for prescription medicines, for either their own use, or for selling to others (Syme and Wong, 1989). This abuse of the trust and intimacy of the doctor-patient relationship has led many GPs to avoid such patients as a group, and it has certainly reduced their involvement in community methadone programmes.

Another perspective on this sort of patient is that their 'narrative' (using the concept of illness narratives from Frank, 1995) is one of 'chaos'. Frank interprets patients' stories as restitution, quest or chaos narratives, and clearly most GPs find it easier to work with patients who comply with the dominant medical narrative of restitution from illness (Kleinman, 1988).

On the other hand, GPs have unique opportunities to observe the natural history of substance use, seeing as they do, patients and families over extended periods of time. Included in this spectrum are alcoholics of all ages, parents and spouses of heavy drug users, those on methadone programmes and those in 'therapeutic-community' rehabilitation programmes.

As a GP in Christchurch in the 1980s and 1990s, that practical experience for me included patients in all stages of

the motivational cycle. It was the 'recovered' patients who made the greatest impression, as they had somehow substituted their chaos narrative for a 'quest' one; a quest to make some sense of their addiction and to re-establish their life in a more authentic way. Their consistent story seemed to be that recovery was in fact possible, that nurses and doctors did not understand the nature and processes of addiction (even 'getting in the way' of possible recovery), and that for them, drug substitution programmes were counter-productive in the long-term.

Their experiences were in direct contrast to the prevailing ideology in Christchurch at the time that 'brief interventions' were just as effective as long term immersion in a therapeutic community, and that addiction, in and of itself, was not a problem, just the social consequences were.

The AA Model

In the spectrum of drug treatment programmes, Alcoholics Anonymous (AA) is a curious case. It is a grass-roots, no cost option, yet curiously it has not been enthusiastically endorsed by health providers as part of treatment protocols. It would be glib to suggest how it actually works, although it clearly helps to resolve the central issue of drug dependency, that of the illusion of control. It seems that by paradoxically admitting powerless, the recovering alcoholic or addict can in fact regain some power over a chaotic existence.

This is a striking phenomenon. In no other major disease with comparable morbidity and mortality can a self-driven change of attitude or belief reduce the long-term risks to mind and to health, and in narcotic dependence these risks are considerable.

Historically, the observation that recovery is possible has fuelled the 'pull-yourself-together' form of response to drug problems, famously illustrated by Nancy Reagan with her "Just say NO" slogan in the 1980s.

Literature Trends

Unfortunately, the Cochrane Collaboration has yet to publish a definitive review of research on methadone or other rehabilitative programmes. In the absence of this type of systemic meta-analysis, a review of the BMJ was illustrative of publishing trends on substance abuse in mainstream literature. In the 1990s there were several editorials, many letters and the occasional research report.

Sorenson (1996) for example, was typical of the reasonable editorials that noted the risk of HIV had been reduced in the UK for those on methadone compared to those untreated. He pointed out though, that reports from Europe (Grapendaal, 1992) were less enthusiastic about reduction in drug users' criminal behaviour.

In terms of letters, many seemed to be noting an increasing methadone death rate (for example, Greenwood *et al.*, 1997), as did review articles, such as Hendra *et al.*, 1996. Occasional research articles in the BMJ showed positive outcomes in terms of harm reduction goals (for example, Wilson *et al.*, 1994).

These comments are not intended to be a definitive review of methadone literature. What they do illustrate however, is how the voice of harm reduction (including its setbacks) is now dominant in mainstream journals. Despite this capture, the current articles in this journal (Kermack, 2001, and Townshend *et al.,* 2001) still seem to be arguing against (a nearly invisible) dissenting voice, turning now against those within their own programmes who are not following the party line.

Summary

In my view, a change in legislation is probably required, as treatment for dependency would be considerably facilitated if the patient is viewed as having an illness, rather than as being a criminal. That aside, this essay has deliberately polarised two ideological camps (the moral model and the disease one) to illustrate the ongoing tensions in current discourse of substance abuse treatment. What is evident is a dualistic dialogue between proponents engaged in an historic power struggle over the bodies of desperate, compromised and dependent patients. Many of the broad generalisations and claims of both sides cannot be substantiated by current research; the literature continues to be dominated more by rhetoric than by evidence, where like an old married couple, both sides compare the advantages of their beliefs with the failings of the other.

To some extent these arguments are de facto ones in lieu of discussion on more difficult issues. What is the true rate of 'recreational use' of narcotics in NZ? What percentage of these people becomes addicted or dependent? What is the personal and social cost of one person's addiction? What percentage detoxify successfully in the community? On the other hand, what percentage front up for rehabilitation programmes of some sort, methadone or otherwise? Is there a link between cultural approval of alcohol and increasing narcotic use? Why do increasing numbers of young New Zealanders need to use strong chemicals? Does the increasing rate of youth suicide reflect similar underlying issues? What is an authentic and autonomous self?

In terms of drug treatment options, one resolution would be to use the disease model of addiction as a starting point to get away from simplistic and superficial responses to these patients. What needs to be included though, is a more thoughtful understanding of the complexities of control and volition. Addicted patients may not always be acting coherently or logically, but the possibility of recovery must always be considered to be a realistic one.

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