response
Challenging Perspectives on MMT

David Benton
Chair of the National Association of Opioid Treatment Providers, the Clinical Co-ordinator of the Lakes Methadone Service in Rotorua and Taupo, and the Clinical Director of thd Hanmer Clinic, Tauranga

The preferred and best researched approach to opioid dependency is opioid substitution by Methadone, and as many international experts point out, methadone is a proven and effective approach from all points of view.

Yet controversy and emotion run high when discussing 'best practice' and treatment approaches. The reason for this controversy and emotion undoubtedly lies in different philosophies – ranging from an abstinence focus to a laissez-faire approach to prescribing – and in moral stances of people in the field ranging from authoritarian through paternalistic to co-dependent and messianic.

And although MMT is successful, it still suffers a bad reputation. Robert Newman, one of the founding fathers of methadone treatment, states that the success of methadone maintenance treatment is irrelevant as it relates to funding, implementing or regulating treatment (cf: Mcqueen, 1998). MMT in New Zealand, as it does around the world, operates in a landscape of conflicting demands and expectations. There are the demands and expectations of Health Funders, and of clients (consumers); there are the demands and expectations of other alcohol and drug and mental health services, not all of whom are sympathetic to or knowledgeable about MMT, and there are the demands and expectations of health professionals, the wider community, law enforcement agencies, not to mention the differing philosophies within Opioid Substitution Services themselves.

Moreover, as the history of Methadone Treatment shows, it is a modality very much influenced by social and political attitudes (Payte, 1991). All of this makes what is a very effective treatment modality very complicated and less effective. The two papers published here reflect this background. These two papers discuss the questions of ethics and the provision of Methadone Treatment in New Zealand. Both suggest that certain practices and the attitudes that lie behind them are detrimental to clients, and suggest that practices that have evolved in MMT are more to do with societal or Treatment Service needs than client needs.

While both papers in their own way raise the issue of paternalism by MMT Services and the usurping of client responsibility, the paper by Townshend, Sellman and Coverdale offers a way out of the ethical dilemma that they postulate exists in MMT. The paper by Andrea Kermack stresses the ethical difficulties in achieving 'appropriate balance between addressing the needs of individual and societal harms [that] sometimes override the needs and demands of individual clients'. Both papers reflect the validity of the conclusion reached by The Institute of Medicine in the United States:

> Current policy . . . puts too much emphasis on protecting society from methadone, and not enough on protecting society from the epidemics of addiction, violence, and infectious diseases that methadone can help reduce. (Institute of Medicine, 1990, p.1)

The issues that Kermack raises are less clearly expounded.

For example, in discussing theories of addiction, three models are examined. This is an oversimplification and the three positions would not be embraced by any of the Methadone Services in New Zealand, though individual caseworkers may reflect aspects of these. Most Services in New Zealand would see themselves working within the context of a Public Health Model, and are mandated to operate in the Ministry of Health's framework of Harm Minimisation and Normalisation.

The issue of diverting methadone – a bane for MMT

Services, prescribers, health services, the public, and law enforcement agencies, and a boon for opioid dependent people not on methadone. Kermack discusses one Treatment Service's obviously varying responses to diversion and other breaches of protocol, including withdrawal from MMT. The anecdotal evidence in New Zealand suggests that most services now try very hard to keep people on treatment, in line with the ample research that indicates that compulsory withdrawal from treatment is unproductive at best, and potentially fatal at worst and this places such decisions very much in a context of ethics. Diversion is in fact a much more complex issue than is described by Kermack. Not mentioned for example is the dollar value of diverted methadone and the implications for those numbers who are unemployed, the pressure to supply opioid dependent friends and acquaintances unable to access methadone treatment, and those who are happy to use methadone from time to time but do not want the restriction of a methadone programme.

While some caseworkers will have difficulties with the assertion that their work, described as paternalistic, is unethical, Townshend, Sellman and Coverdale rightfully raise the issue of power and control which lies at the heart of any treatment approach, medical or otherwise. On the one hand there is a client or patient with his/her presenting issues and underlying needs, and on the other there is a clinician who assesses, diagnoses and recommends (prescribes) a course of treatment. In an area such as Methadone Substitution Treatment, power and control does come sharply into focus. Townshend, Sellman and Coverdale look specifically at the entry into MMT as the point at which this focus is most evident. Legal opinion suggests that the notion of informed consent as practised under the National Protocols for Methadone Treatment in New Zealand (Ministry of Health, 1996) would be difficult to uphold in a court of law because of the issues raised by Townshend *et al*.

Thus the points they raise are valid, as are those about programme 'privileges', such as takeaway doses, being related to client compliance. As Kermack acknowledges, case workers in methadone clinics often find themselves fulfilling two contradictory roles for their patients: policing and counselling. On the one hand they are expected to enforce the rules of the program, and on the other they are supposed to develop counselling relationships based on trust. Kermack's final paragraph expresses most clearly the moral and ethical dilemma facing those involved in substance dependence treatment in general and MMT in particular.

Townshend, Sellman and Coverdale propose a way through the dilemma of informed consent by the common sense notion of a two-stage approach. The initial step follows assessment and initial treatment planning which provides access to the undoubted benefits of methadone substitution treatment. This is followed by a further re-assessment leading into an updating of the mutually agreed treatment plan. This approach would in fact fit within the existing protocols.

One aspect of Kermack's article requires comment. Addicts are, as are all people, in fact 'morally responsible and accountable for their actions'. This is not to deny the anecdotal experience of consumers that they can be seen and treated as 'morally bankrupt', but that is about attitudes. Substance Dependence treatment is not an issue of 'weakness of will'. There is a huge body of opinion contained in contemporary literature on Substance Dependence, Substance Abuse, and treatment approaches and opioid dependent people must be approached from this perspective.

Both papers raise valid ethical questions, and while they may also raise some blood pressures, they deserve open-minded consideration.

References

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