response

Methadone Maintenance Therapy

Dr Lee Nixon
Nelson Alcohol and Drug Service

Continuing responses to articles and debate in October 2001, volume 2, number 3 on methadone maintenance therapy.

Kermack (2001) argues that anti-drug regulations have been legislated in response to 'potentially destructive outcomes for user and society'. Cogent arguments have been advanced that these restrictions were initially enacted more for as a means of repression of minority groups (in New Zealand, the Chinese) than from concern for the real harms of uncontrolled use. Like many legal sanctions, the weight of restrictions is born unequally, with members of disadvantaged groups being preferentially penalised. The majority of the harms associated with opioid dependency are secondary harms due to the illegal nature of the drug, the consequent black market sales structure with inflated price, unreliable purity of product, uncontrolled distribution, followed by repeated intravenous injection at the hands of untrained individuals, often under inadequate conditions.

Pure opioids administered under optimal conditions, are relatively safe drugs. Prior to the widespread introduction of legislation proscribing all but tightly regulated medical use of opioids, their use was widespread with minimal adverse consequences recorded. Thus the major 'harms' of addiction are due not to the pharmacological nature of the drug but to the sub-culture which our legislation has nurtured around it.

The opioid dependent are therefore penalised as a result of an unethical act on the part of our forebears (the institution of legislation to support the repression of a racial group). New Zealand society has accepted the principle that our current generation are liable to make restitution to the descendants of those who were the victims of unethical 'land grabs' by our forebears. On the same principle, our opioid dependent must have an enhanced right to alleviation of the distress brought about by legislation founded on an unethical principle.

Throughout the paper she refers to clients of programmes as 'addicts'. While many clients would identify with this label, there is no doubt that this label retains pejorative connotations. It would be better avoided in a discussion of this type.

She presents as axiomatic that 'addicts' present to methadone maintenance programmes (MMPs) 'eager to get their lives back to normal'. The companion paper by Townshend *et al.* (2001) establishes that this is not the case. They suggest that clients present simply wanting to 'change the source of supply of their drug' rather than normalise their lives. While I have argued that the clients' initial motive is more to escape the painful chaos which unsupported opioid dependence has brought, and that changing drug supplier is simply a means to an end, involving for most clients an unwanted change of drug as well as route of administration, the failure to recognise that clients do not necessarily wish to 'normalise' their lives, is a serious omission. In her discussion on 'The Right to be Treated', Kermack adopts the position that to demonstrate appropriate benefit from treatment, clients must be seen to be moving away from 'the drug scene', and states that clients who fail to demonstrate this are 'maintained on the programme with their safety, more than their right to treatment, in mind'. It would generally be considered that demonstration that a treatment reduces risk of death or injury for the recipient would constitute strong arguments for access to this treatment. This confusion is, at least unconsciously, shared by many in the treatment field, and reflects a harm elimination policy based on the 'addiction as a sin' theory. As Townshend *et al.* argue, this leads to conflict between clients and staff, and reduces both the effectiveness and the moral worth of programmes.

She discusses a series of theories of addiction, and the way in

which these theories reflect underlying beliefs concerning the clients' capabilities for free choice. It would have been valuable to have explored the extent to which recent knowledge of the effects of drug use on the neurobiochemistry of reward, development of cue related behaviour, and impulse control (Jentsch and Taylor, 1999) impact on client autonomy, as well as the impact on this of the client's distress as discussed by Townshend *et al.*

She discusses the contrast between the aims of harm minimisation and 'trying to treat the addiction', with an implied criticism that, in New Zealand, opioid dependent persons are able to lead a normal lifestyle on a stable legal source of synthetic opioids without the pressure of ever having to come off the treatment. While it is true that some older clients, or other clients with co-existing disorders, are assessed as unlikely to move beyond continued reliance on opioid substitution, it is unlikely that many staff in MMPs would accept this limited aim for the majority of their clients. For those who are assessed as unlikely to maintain abstinence from illicit drugs without long-term methadone treatment, continuation of treatment is necessary. (See, for example, Hall *et al.* (1998) who in their introductory chapters, discuss the ethical foundation of MMPs, drawing on evidence that for many opioid dependent persons, abstinence based programmes are ineffective, and citing Kant's conclusion that an unattainable goal is not ethically sustainable.)

In her discussion of the Dunedin Centre's programme she lists a series of behaviours which she describes as 'serious breaches of the methadone programme's safety requirements'. While some of these behaviours may well have dangerous outcomes (for example diversion of dose for sale to an opioid naïve person), as noted by Cape (2001) other behaviours such as concurrent use of cannabis constitute minimal additional risk to either the client or other persons. Thus the proscription of these behaviours has more to do with the imposition of a 'methadone and no other drugs programme' (Townshend *et al.*, 2001) than with safety.

In her discussion of the ethics of the response to dose diversion, she appears to adopt the position that the only choice is to 'weed out' the dose-diverter, or to accept that he/she will continue to use his/her dose in an illicit manner. Harm minimisation is conceptualised as an ongoing process involving progressive movement towards less harmful behaviour. For many clients who have been long immersed in a sub-culture with mores very different from that of the dominant culture, it is unreasonable to expect a sudden 'conversion' to an acceptance of a different value system. As noted by Benton (2001), dose diversion, may be a response to many pressures either financial or inter-personal and the response of health workers to this problem needs to take cognisance of this.

Kermack ascribes difficulties in dealing with the breaches of a programme's protocols to 'typical addictive behaviour' which 'can be manipulative and deceptive'. It is arguable as to whether these behaviours are intrinsically components of addiction, or simply behaviours learned as necessary for survival in the face of stigma and the law. Any general practitioner is well aware of the tendency for those with other life-style related disorders such as diabetes or heart disease to be less than frank concerning their smoking or exercise habits. The consumer's perspective is often that deceit is necessary in the face of what is seen as unreasonable responses to honesty: 'If you are honest you are punished'. Thus impairment of communication may be seen as a product of the system rather than of addiction *per se*.

This has a major impact on the response to behaviours such as diversion where a more therapeutic response would be to explore the reasons for the diversion, working to assist the client to employ other responses to the factors which led to the diversion, while putting in place safeguards to reduce the likelihood of further diversion in the meantime. This surely is in the interests of both the individual and society at large. Thus much of the requirement to decide on the priority of either individual or 'potential victims in society' is an illusion produced by shortcomings in treatment programmes. This comment is not intended to suggest that the health care worker does not have a duty to reduce possible harm to other individuals in society during his/her treatment of the addicted client. This duty is not, however, fulfilled by the adoption of a moralistic viewpoint leading to premature expulsion of clients from a programme, as the likely consequence of this is relapse of the client into chaotic use with its attendant consequences to him/her and society at large.

Kermack makes a useful contribution in her discussion of the role of models of the aetiology of addiction in the development and application of methadone maintenance programmes. It is unfortunate that in her apparent unquestioning acceptance

of the validity of a 'methadone and no other drugs' programme, she trivialises some of the important ethical dilemmas inherent in this field. Benton (2001) observes that aspects of the three models Kermack distinguishes may be reflected by individual caseworkers although most services would conceptualise themselves as working more from a Public Health perspective. My personal observation is that health professionals working in this field appear to operate on a continuum of models, each individual operating about some point constituting a balance of moral model and harm reduction which is acceptable to him/her personally, but unconsciously oscillating back and forth between more extreme positions in response to external pressures. This obviously influences the health worker's responses to their client at that time. More formal study of these factors would greatly aid a more professional and ethical response to the many decisions that must be made in administering methadone maintenance treatment.

Turning now to Townshend *et al.* (2001): These authors discuss an important issue, too long ignored in published writings. Although many clients of methadone maintenance programmes (MMP) express appreciation of the stability which the programmes have brought to their lives, anyone working in this field will be aware that it would be a rare client who at some time has not resented the restrictions of 'liquid handcuffs'. The Anonymous Consumer (2001) in his/her comments on this and its companion paper (Kermack, 2001) describes this well.

Townshend *et al.* (2001) suggest that the prime motivation of clients entering MMP is to 'change the source of supply of their drug' which is no doubt correct, but my discussions with clients make it clear that this is a means to an end, the motive in entering MMP being to escape the chaotic life style which unsupported opioid dependence has produced. This change of emphasis in no way negates the argument advanced contrasting short and long term aims of MMP, but reveals yet another paternalistic decision on the part of the treatment field. Entering MMP clients are expected to change not only their drug supplier, but also the drug and its route of administration. Many clients might well prefer to escape the chaos of their lifestyle by receiving their drug of choice by their preferred route of administration, but this option is not presented to them, and unrealistic expectations of rapid adjustment to these two changes is a frequent cause of conflict between client and treatment provider. The successful outcomes of the Swiss, and more recently the Dutch 'Heroin trials' illustrate this. Again, our anonymous consumer elucidates so well the confusion as to what constitutes a 'satisfactory outcome' for a methadone maintenance programme. Few could disagree that the outcomes he/she describes constitute major gains not only for the individual client but also for society.

Townshend *et al.* provide useful discussion of the degree to which a harm elimination approach effects front line providers attitudes, and ascribes conflicts within programmes to a mis-match between these providers aims and those of their clients, together with the degree of invasiveness of MMPs into their clients lives. They might also have noted, a reflection of the paternalism in treatment is the marked difference in the degree to which regional programmes differ in their balance between harm minimisation and harm elimination. This frequently causes resentment, particularly when clients transfer between programmes. What was acceptable in one locality may be met with restrictions seen as punishment in another, even to the extent of making clients ineligible for treatment in the locality to which they wish to transfer. During recent discussions concerning the revision of the National Protocol for MMP, representatives of the Ministry of Health have reported that the bulk of submissions from consumers, have been requesting more consistency between local programmes in these matters. Barron (2001) highlights the lack of logic that allows local programmes to develop their own protocols incorporating more stringent demands on clients than appear to be intended in the National Protocol (1996).

While this is an important issue, I am surprised that these authors fail to mention a much more negative outcome of this aspect of paternalism, a feature which is frequently complained about by dissatisfied clients. The provision of unwanted counselling and intensive monitoring, especially in relation to takeaway privileges when these are made contingent on compliance with a 'methadone and no other drugs' regime, absorbs a large amount of staff time and other resources, in a system known for long waiting lists. Given the problems of untreated opioid dependence, as discussed in this paper, prolonging waiting time for entry to programmes must constitute a major harm, and is without doubt the most serious consequence of the paternalistic decision that all MMP clients must share the long term aims of the providers.

Townshend *et al.*'s suggested strategy is effectively the

provision of a tiered level programme, where clients are initially established on a safe therapeutic dose of methadone with little monitoring and no takeaway privileges, later being offered the choice to move on to a programme offering the 'chronic benefits' of the programme. As noted by Cape (2001) there is now evidence that the simple provision of methadone provides significant benefits, supporting this approach, and a recent review has added strength to this (Langendam *et al.*, 2001). Cape points out how this suggestion also has the potential of making more efficient the input of specialist clinics, and is consistent with the Ministry of Health's stated agenda of moving treatment of opioid dependence into primary health care, fitting well into the concept of shared care. As he notes, a major advantage of this approach would be reduction of waiting time to access methadone treatment, as any waiting list would then impact at the point of access to ancillary treatment, rather than at the initiation of treatment as at present.

In his review, Wilson (2001) criticises the paper by Townshend *et al.* as 'chillingly narrow in its ideology, implying that health care workers who deviate form clinic policy can be identified, labelled as paternalistic, and brought back into the fold'. My reading of this paper is more that it is intended to challenge both 'coal face' workers and the makers of policy, by clearly identifying many of the current practices of methadone maintenance programmes as practices emanating from the provider's moral stance, leading to the imposition of goals not shared with or even accepted by the client. Wilson seems to arrive at his position from a fear that harm minimisation is incompatible with a long-term goal of abstinence, drawing upon his personal positive experiences in general practice with 'recovered' patients.

I too, share many satisfying memories of patients in this condition, but also retain all too many memories of situations where persistence with the immediate goal of abstinence, beyond the point where this had clearly been demonstrated to be impractical, had major costs to both patient and family. The ultimate in harm minimisation is abstinence. The routes to abstinence are many, and for some, tortuous and long.

References:

Anonymous Consumer (2001). Methadone Maintenance Treatment: The Consumer Perspective. *New Zealand Bioethics Journal* 2:2, pp.26-28.

Barron, P. (2001). A Community Pharmacist's Perspective on the Methadone Maintenance Programme. *New Zealand Bioethics Journal* 2:3, pp.35-36.

Benton, D. (2001). Challenging Perspectives on MMT. *New Zealand Bioethics Journal* 2:3, pp.33-34.

Cape, G. (2001). Appropriate Versus Practicality of MMT. *New Zealand Bioethics Journal* 2:3, pp.23-25.

Hall, W., Ward, J. and Mattick, R. (1998). Introduction. In Ward, J., Mattick R. and Hall, W., *Methadone Maintenance Treatment and other Opioid Replacement Therapies.* Harwood Academic Publishers, Amsterdam.

Jentsch, J., Taylor, J. (1999). Impulsivity resulting from frontostriatal dysfunction in drug abuse: Implications for the control of behaviour by reward-related stimulu. *Psychopharmacology* 146, pp.373-390.

Kermack, A. (2001). Ethical Aspects of Substance Abuse and Intervention: Reflecting on Methadone Maintenance in New Zealand. *New Zealand Bioethics Journal* 2:3, pp.14-22.

Langendam, M., van Brussel, G., Coutinho, R. and van Ameijden, E. (2001). The impact of harm-reduction-based methadone treatment on mortality among heroin users. *Amer J Public Health*, 91, pp.744-780.

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

Townshend, P., Sellman, J., Coverdale, J. (2001). A Preventive Ethics Approach to Methadone Maintenance Programmes. *New Zealand Bioethics Journal* 2:3, pp.7-13.

Wilson, H. Competing Ideologies in Substance Abuse Treatment.