case study

Louis is a thirty-five-year-old who has been on methadone for some time. He has a 15-year history of opioid use composed of varying numerous lengths of abstinence and heavy use. He regards himself as 'not a junkie' as his most recent period of opioid use started when he was abstinent and was prescribed morphine sulphate (the most commonly sought after street drug) by a GP as a result of chronic pain due to a back injury received in a motor cycle accident.

Louis has been difficult to engage in any kind of counselling process, as he is often arrogant and abusive in interviews. However he does attend most interviews. His urines have always been free of Benzodiazepines and opioids but contain cannabinoid and occasional amphetamines.

Currently Louis picks up his methadone on Mondays, Wednesdays, and Fridays. However Louis has been asking to have methadone doses to take away with him as he has a job at a vehicle wrecker and could work more hours if he was able to self dispense methadone on more occasions. For some time he has been requesting a split dose as he finds that after a hard day in the wreckers yard his back gives him trouble and by splitting his takeaway doses and having a half dose at night he gets pain relief and improved sleep.

There have been consistent reports from other clients that Louis sells his methadone and although the pharmacist has never had hard proof, Louis is always quick to exit the shop following receiving his oral dose. Louis has just been convicted and given a non-custodial sentence on a charge of possession of morphine sulphate. He claims this was old medication which he had forgotten but remembers that he put into a different container once in order to be less conspicuous when he was going away for a weekend. Louis has been told the treatment team is contemplating taking him off methadone.

commentary

Consumer Perspective

Name withheld by request

This case demonstrates the regional variations with methadone prescribing. If he were receiving MMT in Dunedin he would be extremely unlikely to be picking up his methadone only three times a week. If there were questions about him selling his methadone the likely first action would be to remove these takeaway privileges. Removal from treatment would only follow if there were further problems.

Louis is described as difficult to engage in counselling. It may be that he doesn't want, or even need, counselling. Most clinics seem to acknowledge that all some clients require is a monthly 'check in', with an offer for more in depth sessions if needed.

I am particularly concerned when accusations by other clients are used as a ground for clinical decisions. In some cases accusations could be borne out of genuine concern, but I know of people who have been 'told on' by someone because they refused to sell their methadone – i.e. as revenge. There could also be a jealousy factor. Some consumers would react in this way as Louis gets more takeaways than them – i.e. he is seen to receive preferential treatment. Most MMT consumers don't participate in this sort of behaviour, but a few do. This is probably a symptom of the powerlessness that many consumers feel. And perhaps he leaves the pharmacy quickly as he has to get to work.

I have difficulty with the drugs conviction being the reason to terminate Louis's treatment for several reasons. Firstly, he could be telling the truth. The instinct of most people reading the case is likely to be 'yeah, sure'. Would this be the response if it was a lawyer who was found in possession of medication he was prescribed several months ago? Would the lawyer even be charged, or would it be accepted that (s)he had put it in a non prescription container for the reason given, particularly if that lawyer had provided several urine specimens over previous months that were free of morphine (as Louis has)?

And if the conviction is correct and fair? He has breached the safety requirements of the programme. This may be because he is still in pain, can't get the split dose he has asked for, and can't get other pain relief because he is on methadone. Whatever the reason, at worst he is displaying the symptoms of the condition he is having treated – addiction. This should not be a reason to withdraw that treatment.

It could be argued that there was a breach of contract. As explained in Townsend *et al.* in the last issue, people wanting to get on methadone will sign anything. The contract has little actual value unless both parties are in a position to negotiate the terms.

In defence of methadone programmes – in my experience people usually have to repeatedly breach the programme guidelines before their treatment is terminated. A usual first step would be removal of take away privileges. This would stop any selling of methadone. I can also understand their concern with people selling their methadone. As well as a genuine concern that people may overdose, there is also the fear that this practice brings a lot of negative attention to the methadone programme.

The many legal requirements of the methadone programme, as well as society's moral attitudes, contribute to conflicts that arise between consumers and providers. Attitudes to methadone consumers (and injecting drug users) with genuine pain relief needs adds another source of conflict. Situations similar to Louis's are not uncommon.

Reference

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

commentary

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This interesting case is typical for a specialist drug clinic to deal with. However, the vignette provides insufficient information to give detailed management suggestions. First we must be clear about whom we are trying to assist and what the nature and extent of his problems actually are. We know Louis has a part-time job at a vehicle wrecker's but we do not know his relationship status, home situation, ethnicity, or connection to extended family. We do not know if he has any non-drug using friends. We need to assume his opioid use has been via the intravenous route and has followed a typical dependent pattern. No diagnoses (substance use, psychiatric, medical) are provided, nor sufficient information to make them.

He is noted to be difficult to engage. This is a fundamental problem. Is this on the basis of personality difficulties, mood problems, low-grade irritability from ongoing cannabis withdrawal, brain head injury sequelae, a 'normal' frustrated reaction to perceived mis-management by the clinical team, or as is most common, a combination of a number of these and other factors?

Why should he regard himself as a 'junkie'? He is a person, who (presumably) with considerable current drug and pain difficulties needs to be conferred with patient status, comprehensively and respectfully assessed, understood and then expertly cared for. He is highly likely to have suffered a lot in his past but no childhood/family upbringing history is given.

How long did he wait for methadone? The intolerable time many people are 'left to rot' on regional waiting lists is a scandal and amongst other things can seriously undermine the development of secure therapeutic relationships from the outset.

What has been the pain workup for Louis? If he does have a chronic pain syndrome along with opioid dependence, then a shared care arrangement needs to be fostered between his pain

and drug specialists, following the identification of a clinical case manager who will facilitate integrated management and care including his GP. If he hasn't got a GP then he needs help to find one with whom he will develop trust over time.

A fundamental rehabilitative issue is work. Current restrictive takeaway dose policies often undermine the ease by which patients are logistically able to engage in normal work. However in Louis's case there appears to be some basic assessment and stabilisation work to undertake before reintegration into normal life. A significant minority of patients do not stabilise on one dose of methadone a day, particularly when there is a pain component. In any event, there often comes a time in clinical practice that a calculated degree of risk must be taken in order to actively assist people into education, re-training and work opportunities, which involve takeaway doses.

Finally, even with best expert efforts, some patients do not stabilise their drug use and 'drug seeking' continues to predominate over 'treatment seeking'. Low fixed dose treatment options provide a 'purgatory position' whereby a positive connection is maintained with the programme, while patients remain contemplative regarding more comprehensive treatment.