Response
A Community Pharmacist's Perspective on the Methadone Maintenace Programme

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The service in our pharmacy is based on the premise that all clients should be treated with equal dignity and respect and simply as human beings with a health-related problem. We regard our Methadone clients as amongst our most valuable clients and we treat them accordingly.

The present review of the National Methadone Protocol illustrates the frustration that many pharmacists feel with the MMP – we are regarded as an integral part of the team but in reality our role is reactive rather than pro-active.

There are three recurring themes through the draft MMP protocol that deeply concern me.

1. There is constant referral to the pharmacist as a key member of the client management team, but there is little of any substance in the protocol, that provides for the pharmacist to have an active, as compared to a reactive, participation. Of those involved in the provision of MMP services it is the pharmacist who sees the client every day, it is the pharmacist who interacts with and observes the client every day, and it is the pharmacist who is most likely to be aware of the personal circumstances and the day-to-day personal and health issues of the methadone client.

In many ways pharmacists are the health professionals who have to make the most difficult ethical decisions in regard to MMT clients. Frequently pharmacists are faced with making a choice between reporting incidents or in extreme cases withholding doses in strict adherence to the Methadone Protocol, or, based on our experience of the client, allowing an incident to pass because we feel that it is in the client's best interest i.e. the private good versus the public good.

Clearly many clients on MMT are extremely manipulative and will stop at little to get what they want. As familiarity grows it is often difficult to maintain objectivity without becoming paternalistic.

Nevertheless because of the close relationship that many pharmacists develop with their clients they frequently find themselves cast in the role of client advocate with counsellors, doctors, police and government agencies.

Despite this, the protocol makes no provision for the pharmacist to receive information by right, or to be actively consulted by right. It is difficult to escape the conclusion that the protocol is more about counsellors and prescribers rather than effective provision of services to clients.

2. One could be excused for believing that by definition the national MMP protocol exists for ensuring a consistent service delivery throughout the country. Regrettably the national protocol allows specialist services to develop local protocols around the prescription and use of other drugs. This unfortunate state of affairs causes a lot of stress and difficulty for both clients and pharmacists and generates equity issues for clients with respect to both treatment and options.

Pharmacists are confronted every day by clients who are forced back to the street to obtain drugs such as benzodiazepines simply because the specialist service will not prescribe. The dangers inherent in prescribing some drugs are well understood, but faced with the reality of either having clients prescribed known drugs in known quantity versus purchasing on the street, it can be argued that prescribing is the lesser of the two evils

Given the depth of international and local experience with MMT, and given that it is a tax-payer funded service, it is difficult to accept that there can be any reasoned argument for allowing providers to work outside of the protocol. It is a nonsense that specialist services should be allowed to develop local protocols. There must be national consistency based on best practice and this must be protocol driven. There is no clinical or ethical validity for any other approach if the programme is truly about clients and not about providers.

3. Whilst there is reference to stabilisation on a comfortable dose of Methadone nowhere is there any reference in the draft protocol to ensuring that the dose is a pharmacologically effective one. Given the ample literature on the most effective doses of methadone it continues to cause surprise that many clients continue to be under-dosed. Thus it is little wonder that many MMP clients continue to use other products obtained on the street. One is left pondering the ethics of sub-optimal dosage.

Finally there are two further aspects of the MMT that should cause deep ethical concern.

1. It is difficult to understand the pharmacological or rational basis for insisting that sentenced inmates in prison are withdrawn from Methadone. Given the fact that this is Methadone Maintenance Treatment one wonders why those receiving a legitimate treatment should be subject to such irrational protocols especially when the objectives for opioid treatment are considered. If the Prison service logic is followed then treatment for diabetes and asthma should also be forcibly withdrawn!

2. The failure of pharmacist's professional body (The Pharmaceutical Society of New Zealand) to mandate that pharmacists have a professional obligation to provide MMT services. Personal opinions, no matter how strongly held, should never be allowed to override the rights of the patient to the provision of a service that they are legally entitled to receive. The profession does not tolerate a pharmacist refusing to dispense an antibiotic to somebody whose appearance or attitude or personal circumstance they find objectionable. Why should a pharmacist, or a doctor for that matter, be permitted to choose not to provide service on the basis that the client has an opiate addiction?

It is difficult to escape the conclusion that the pharmacist is an integral and essential part of the case management team and consultation with the pharmacist must occur. The major weakness of the present system is that the pharmacist is not provided with information about the treatment plan, nor of the background/issues/living circumstances of the individual client. Thus the pharmacist, the health professional with the most regular and intimate contact with the client is consigned to the role of dispenser of medication rather than being an integral part of the case management team.

Clearly there are resource implications – however if the desired end-point is successful management of the individual client then clearly there is greater potential for successful outcomes with long-term economic and health gains if the pharmacist is actively involved.

Author Biography

Peter Barron is a community pharmacist who manages an innovative pharmacy practice in Dunedin that provides Methadone services to 30 clients with a contract to provide services for up to 100 clients. The pharmacy operates a Level 2 Needle Exchange service i.e. they supply individual needles, syringes, filters, catheters etc. to IV drug users for the purposes of reducing risk to users and to the public.

Reference

Ministry of Health (2001). Protocol for Methadone Maintenance Therapy in New Zealand, draft for comment. Wellington: July.