Methadone opinion dangerously blinkered

I struggled long and hard to resist my attempts to respond to your anonymous correspondant, 'John' (*DDN*, 5 September, page 8), because everybody is entitled to an opinion.

But John's piece falls foul of two particular ideological engines: the cyclical fashion trends that the drug treatment field succumbs to, and the tendency of both service users and practitioners alike, to try and extrapolate from their own experience to the needs of the general population.

Unlike John, I started using opioids in the early seventies, but I was fortunate enough to live in an area that had a sensible doctor who, though he may not have had a mountain of randomised controlled trials, could see from his own clinical experience that methadone was having a positive impact on some of his patients.

But the drugs field has always been driven by fashion, not evidence. So in the sixties and seventies, methadone was in; then in the eighties, methadone was out again.

Over the last few years, the NTA has insisted on practice being grounded in evidence based research, and so naturally, as there is an overwhelming preponderance of evidence in support of methadone maintenance, it's hardly surprising that attempts to improve both the size and the quality of the treatment field in the UK will initially focus upon methadone treatment as one aspect of their work.

I'm glad that John was able to successfully complete his residential rehab, and that he was able to sustain his sobriety afterwards. However, I'm sure that he's only too well aware that not everybody wants or is suitable either, for abstinence based treatment – and even of that proportion who do opt for it, a very small proportion actually complete the programme, let alone manage to sustain their sobriety afterwards.

And do some people stay in methadone treatment for a long time? Why yes, they do. That's rather the point of the whole thing. Dependence on opioids is a chronic and relapsing condition. Research shows that the average drug-using career is around 13 years. Now, many people will quit after the first year or two. Others though, will be using for 30 years or more. The question then is, do we abandon these people to a life of street use, crime, poor health and disease, or do we offer them a treatment that is proven to reduce the prevalence of all of these issues? I think we already know the answer to that.

But the thing that angers me most about John's comment is the implication that methadone isn't a legitimate form of treatment and one form of recovery, but is simply another type of drug misuse. As somebody who has been in methadone treatment for the last 30 years, I've managed more than a couple of accomplishments during that period. Accomplishments like a first class degree and a masters. Careers in the drugs field, journalism, and IT. Like successfully raising three wonderful children, one of whom works in a bank; the middle one is just about to leave home for her university course in journalism.

Could I have achieved more if I'd been abstinent? Well, perhaps. The fly in the ointment though, is that I'm just not convinced that I ever would have been able to achieve abstinence. It isn't as though I never tried. In fact, in my experience, most long-term users make numerous attempts to quit – and some proportion of them do inevitably fail. For people like that, and I include myself in that number, methadone has saved our lives – indeed, given us a life where before we just led a depraved existence.

Which is not to say that there shouldn't be decent abstinence treatment available to all who need it. I regularly speak to service users who tell me that they are desperate to get into a residential or in-patient detox facility because some arrogant worker (or even, in some areas, a commissioner) has judged that they 'aren't ready for it yet'. Of course, if they'd bothered to read the research, they'd know that there is no way whatsoever to reliably predict who will or will not achieve and sustain abstinence after a period of structured care away from their usual environment. Prior motivation certainly isn't a predictor, and so in light of that, surely we have to let everybody who wants to try this sort of treatment take a shot at it.

Surely this field is mature enough now to be able to take that message on board, without denigrating a form of treatment that works very well for a great many people. And where it isn't working that well, rather than denigrating the patient, one has to ask oneself exactly what it is that the paid professionals do in these circumstances? If a cancer patient isn't responding to chemotherapy, the oncologist tries something different. Many people working in drug treatment though, seem only to happy to let their patients stumble along with one particular treatment regardless of whether there are any improvements in their personal circumstances.

Hopefully, these are some of the issues that the NTA's effectiveness strategy will begin to address over the next three years. And as an NTA board member with three children between the ages of 17 and 25, I'd be happy to respond to John's question about what sort of treatment I'd want for them if they came to me, telling me that they had a problem and needed treatment. Personally, I'd want them to be able to access treatment that was both

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effective and suited to their individual needs. If that meant residential rehab, then fine. However, if it meant methadone maintenance, then that would be fine as well. The reality is that most people will generally try a range of different treatments before finally hitting on the one that works for them. The sooner they reach that point, the better.

Peter McDermott

A suggestion on public liability insurance

I read with interest your article on the discriminatory effect of the Rehabilitation of Offenders Act and the resultant difficulty in setting up community projects (Alliance column, *DDN,* 5 September, page 5).

Back in the nineties, I worked for a large housing association and, together with a group of like-minded individuals, decided to do something to offset what we thought to be the 'draconian anti-asylum regulations'. We met with the usual difficulties of getting insurance, but found that medium to large institutions, (housing associations, charities, *etc)* tend to be a little over-insured and can extend their insurance cover to develop new projects and pilot schemes at zero cost. This was certainly the case with my employer and we were able to resolve that difficulty.

It might be a good idea to talk to some of the larger players. They can get all sorts of good PR and goodwill from potential funders to give you a hand, without it costing them anything. It also looks good to agencies you might be approaching for support, particularly in the current climate where partnerships are very much flavour of the month.

Kevin Patton, Mainliners

Sweeping statements are cause for concern

I found the letter from Roy Fisher, 'Let's challenge addiction, not collude with it' (*DDN*, 5 September, page 8) very concerning. Never have I read such arrogant and misinformed twaddle. The fact that this comes from someone who works in the field is even more alarming!

I guess I must be one of those 'people' like Mike Linnell. I fully hold my hands up to thinking about addiction in practical terms. To say that addiction has no rhyme or reason to it is down right stupid. There are many reasons why people become locked in a world of addiction – and many more reasons that keep them there. To make statements like this shows a total lack of understanding of problematic drug use – worrying to say the least.

Making sweeping statements saying that 'educating' drug users is a waste of time and effort, is offensive to both drug users and workers alike. My experience of working in the field for 18 years, and having been around drug users for over 30 years, I know drugs users can and will make positive changes – given the right support and treated with respect and dignity. Of course there are going to be some who will continue to engage in high-risk activity. Yes, people will continue sharing syringes for all the reasons Roy Fisher states. But surely this only confirms the arguments that services should be meeting the needs of those clients who are at most risk, by making their services more accessible, less punitive and operate in hours more conducive to a drug users lifestyle.

'The best form of harm minimisation is not to use drugs'? How patronisingly insightful! The fact is that many people do choose to use drugs and therefore they have a right to truthful and factual information if we are to reduce harm. And whilst there may well be no 'safe' way to take drugs, you can certainly make it 'safer' – just as you can sex. The best way to not catch sexually transmitted infections is to not have sex, but we know that is unrealistic. So why should drug use be viewed any differently or less pragmatically than sexual health education?

Certainly, quoting theoretical models

does not make anyone an 'expert' – but then again neither does being an ex-user either. The fact is that the majority of people who use drugs do not have problems with them. Just because Roy Fisher had a problem with his drug use does not give him exclusive insight or expertise into the world of addiction – not everyone's experiences are the same. I know many current and ex users who would totally disagree with his sentiments and would find them extremely offensive and patronising to say the least.

Roy Fisher fails to fully grasp the true spirit of the harm reduction philosophy. Harm reduction has many aspects and if someone wants to become drug free that is also part of the continuum of the model. Those who believe in harm reduction don't preach to their clients, they help facilitate positive changes. Methadone is only one component of harm reduction – but it certainly has made an enormous difference to many people's lives.

Lyn Matthews

Giving choice is the only decent model

Whilst not wishing to carry on a personal literary spat with Roy Fisher (*DDN*, 5 September, 11 July, 27 June) – I don't think you're a weak-minded moron Roy, I just think your argument was shit – I do think the issue raised by his reply to my 'vitriolic' response to his original letter and the letter from 'John' on the same page is worth arguing about.

I agree with some of the things Roy now says in his reply, but there are just one or two points I'd like to pick up on. Whether I think methadone is 'helpful ' or not is not the issue, as there is clinical evidence for its effectiveness. Is methadone helpful for everyone? Of course not. Is methadone 'useful in the short term under medical supervision when detoxing'? No: it's rarely used for that anymore as the evidence says it has a dire success rate – that's why we go to the trouble of getting evidence. Do I think its right to breach a client on a DTTO who refuses methadone? No, of course not. But that is a failure of a system and whoever's job it was to work out your clients care plan – not of methadone.

Is the best form of harm reduction not to use drugs? Of course it is, but so what – I also think an end to poverty, starvation and war would be a good thing, but I don't know how to achieve that either. Do I 'support a model that helps virtually no-one'? What model? I support giving people choices – nothing works for everybody. A hundred yards from where I'm sitting we run a needle exchange and in the same building we have the base for a 'home detox' service. The needle exchange has 3,000 users at any one time – the home detox service is lucky to have a dozen – does that tell you something about people's choices? Do I think people who want detox and rehab should get it? Absolutely, rehab works for some people, but for many more they don't and never did – even in the days when that was the predominant philosophy. Which brings me on to John's letter.

Dear John, I'm glad you have a good life now, thanks to the kindness of your parents paying for you to go into rehab, but I'm sure you are aware that the vast majority of clients of drug services aren't so lucky. I presume you, like me, don't think it is a coincidence that drug services' clients tend to come form the poorest most marginalised sections of our society and that not many on benefits can afford to maintain a habit.

I'm sure you must have noticed that people are currently being drug tested when they are arrested and can be given the option of compulsory treatment rather than prison. Conservative Party policy going into the last election was to (somehow) create 20,000 rehab places and like you and Roy, they presumably believe (without any evidence) that this will be more effective than the current treatments on offer. Now let's see, a client is on a DTTO but wants state funded rehab rather than methadone, so the courts send them to rehab rather than jail. Do you think they will have the option of going home if they can't stand it? What happens to those who 'split', will they go on the run? What about those who get caught using in rehab, will they be sent to prison or given 'extra days' on their treatment? If rehab is compulsory, why not just call them prisons in the first place; if rehab is voluntary, do you think any government would spend billions setting up and running them?

John asks emotively at the end of his comment, 'if your son or daughter came to you and admitted they had a heroin addiction, would you be satisfied if they went to a drug service and ended up on methadone maintenance, or would you want them to go away to a first rate rehab, get the help, motivation and encouragement to come off drugs and stay that way?' Let me ask you this John, would your parents have preferred you to have been maintained on methadone rather than put them through the 'madness' you describe between '81 and '87? Would rehab have worked for you in 1981?

Would you support methadone for people waiting to go into 'first rate rehab'; would you support it for those who couldn't stick with the programme or had tried rehab before and failed? Would you support methadone for people who don't want to go to rehab or have been successfully maintained on methadone for many years and don't want to stop it? Would you take it away from them?

Comment

Coercing people into treatment – Does it work?

In every industry there are phrases that have become tantamount to cliché, phrases that every worker takes for granted and follows unquestioningly.

In IT it is 'it's not the computer it's the operator', which we all know is up for debate. Every drug and alcohol worker will, almost to a man, say that drug and alcohol work at tier 2 level is voluntary. It has to be they will say, otherwise it will not work; a person has to have accepted that they are concerned about their use before they can then work on it. In motivational interviewing it is called being in contemplation stage. The benefits of a client already prepared to work on their concerns are apparent – however in today's system, is it really the case that every client attends their sessions with a drug and alcohol worker voluntarily?

Working within the criminal justice system it becomes immediately apparent that very rarely are things said categorically and set in stone. In this era of appeals, and more importantly the financial penalty lavished on an organisation that gets caught up on the wrong side of an appeal, outright protestation is fast becoming a thing of the past. As a result work is undertaken on a double layer – what is being said and what is being meant – and the clients too have noticed and accepted this style of working. Which means misinterpretation is rife.

So when a probation or a youth offending team worker suggests a session with the drug and alcohol worker, what the client often hears is 'if you don't go, I am going to breach you' and responding in the same double layered style, the response is 'of course I'll go, I'd like to work on this'. Through no-one's fault, a non-responsive client ends up sat in front of a worker, both of them mildly bemused at the situation.

The criminal justice system isn't the only place where the boundaries can get blurred. Incentives to engage with substance misuse work can often be misconstrued by the client as leverage. When a social worker, who is involved with the family in child protection procedures, suggests involvement with a drug and alcohol charity or organisation, the client is naturally going to feel obligated.

The biggest issue with coercion into treatment is that it is not overt and indeed, workers usually don't realise it is happening. It is a product of a change in culture towards softened words and double meanings, which service users have recognised and adopted accordingly.

So the big question is: can treatment at a tier 2 level be of any benefit to the client at all? Well first of all, it depends on the type of work being delivered. If it is counselling, it is unlikely that the work will achieve its potential. It is in this situation that the coercion factor can be detrimental. It can increase feelings in the client of being talked at; it also undermines anything discovered by the client in the counselling process, because it will be attached to feelings of defensiveness and lack of control. To the client it can appear that indeed those feelings are induced by the systems that forced them to be somewhere, totally devaluing them in the client's mind.

In simple one-to-one intervention and support, like that provided by probation officers and youth offending team officers, it will of course never be as effective as it would be in an entirely voluntary situation. However it does provide a platform for awareness-raising and possibly minor harm reduction work. It may create a situation that will lead the client into the contemplation stage or be a catalyst that brings the issue to the forefront of the client's mind.

It also provides the opportunity to at least try to ensure that the client is safer, opening discussion over the specific dangers – issues such as clean needles, using around trusted friends and discussion over date rape with alcohol use. Although it would not be able to move past the information stage, it means that the information is being given to those in more need and who may not look at the material sent to youth clubs, libraries *etc* – so those who would not seek safety information by choice are at least being told the realities. It will not stop the use, but may reduce the number of deaths associated with substance misuse.

The old adage is true: a captive audience will listen. They may not change their behaviour, but at least they may do it more safely. Most workers will agree that anything rather than nothing in some situations is better – provided workers realise that counselling or high-end work on behaviour change is detrimental in a situation in which a client is feeling coerced, but awareness raising and safety information is still a step in the right direction.

So although the foundational belief of substance misuse workers is true, that change has to be on a voluntary basis, awareness and support can still be of benefit even when coercion has either directly or indirectly been applied, intimated or interpreted.

Caroline Spillane, drug and alcohol worker, Torfaen and Monmouthshire