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Maintenance worries

The article 'Different Roads' (*DDN*, 19 May, page 6) is one of the most important and poignant that *DDN* has published so far, not least for the erudite weight given to the subject by the status of the authors, who are perhaps the foremost authorities on research evidence for treatment outcomes in this country.

I feel very emotional after reading the piece because, as with many others, abstinence-based recovery not only saved my life but has been ongoing in helping me to achieve my potential as a human being. It allows me to draw on my true inner resources for spiritual development through, in my particular case, meditation practice and fulfilment through work, which, as it happens, is in the field of addiction treatment.

It is not a coincidence, I believe, that all spiritual disciplines (apart from the perverted ones) or paths of personal progress and self-realisation recommend total abstinence from intoxicants of all kinds. This is because, in my view, intoxicating substances at best mask or act as a barrier to the realisation of inner potential, whether spiritual, mental or physical. Most, if not all, 'maintenance' substances cloak potential for personal inner growth in a suffocating chemical blanket.

This is not to say that reduction regimes are not useful and even imperative in detoxification protocols; this is where there is a clear valuable and relevant use for chemical support.

Since the dawn of time, the spiritually-realised and more highly advanced members of all human communities have pointed to abstinence from all mood-altering substances and behaviours in order to achieve stability and progressive-development on a personal level for all individuals who want to travel a path to the achievement of full individual human potential.

To arrest active addiction – the inevitable result of sustained indulgence in more or less all mood-altering chemicals – there is ultimately no other way than eventual achievement of total abstinence from all toxic substances. It is as simple as that, basically. Substituting one addictive substance for another, even more addictive substance, is both baffling to comprehend and ridiculous to contemplate.

There is a place for harm minimisation, of course there is, and it is so important that non-abstinence-

based services nowadays exist to serve the needs of those who cannot achieve abstinence, especially in the initial stages.

It is the 'maintenance' culture that troubles me. If doctors sanction maintenance prescriptions because of the 'above all, do no harm' ethic, well... they might need to re-evaluate their understanding of ethics. They may be getting it the wrong way round.

John Graham,
self-employed addiction treatment practitioner

A singular lack of evidence

David Best, Jessica Loaring, Safeena Ghufuran and Ed Day really do need to get out of the lab a bit. Their conclusion at the end of their article 'Different Roads' bordered on the absurd.

'We should not give people the impression that they can have maintenance and abstinence' they proclaimed. Well, we aren't, so don't worry about it. They state that the idea of 'reduction towards abstinence' is a 'moot point'. Well, until they can find a better, more cost-effective way of moving toward abstinence this is the only relevant debate.

Most, if not all, drug workers and NHS prescribers with whom I have worked will indeed encourage abstinence to all but the most chaotic. Now, granted, this abstinence may take some time, with scripts being reduced over a period of years and lapses occurring frequently, but the intent is still there. Surely improving the likelihood that such people will achieve this abstinence should not be sidelined? Yet this was the conclusion of the article.

But to their original point: medicated recovery is a fallacy, the only way forward is abstinence. The article failed to offer anything by way of proof that this was true. It just took it as fact and moved on. It implied that 'housing, employment and effective social reintegration' was somehow a poor way of judging treatment outcomes, then went on to imply that such wishy-washy (not to mention almost incalculable) terms such as 'hope' 'engagement' and 'commitment' were the proper ways to define 'true recovery'.

They state that engagement with services two or more times was a predictor of poor abstinence outcomes. However, they fail to prove a direct

correlation with these two pieces of information. A simple explanation might be that the more chaotic users are more likely to attempt (and fail) treatment and that the less chaotic are more likely to get treatment right first time or even attempt abstinence without need of formal intervention.

This lack of evidence for their supposed proposition ('medicated recovery doesn't exist') leads directly to the question: 'Why knock the achievements of those that have actually achieved medicated recovery?' We should have no doubt that they do exist – I imagine there will be a flurry of letters from just such people, outraged at the suggestion of this article's authors that their recovery is worthless.

And what have the authors achieved by attempting to undermine these people? Well, little to nothing from what I can tell. Spawned an unoriginal and ultimately pointless article that fails to add to an already tired debate, maybe generate a bit of publicity for their forthcoming research. Well done guys, I can see why you get your research grants...

Stephen, by email

Mutual necessities

While agreeing as I usually do with much of what my friends David Best and Ed Day have to say in 'Different Roads', I found their conclusions puzzling.

As some know, I have been banging on for years^[1] that harm reduction and abstinence treatment modalities (or philosophies) are not mutually exclusive, they are in fact mutually dependent – and I have never found that 'juggling both is unlikely to succeed'.

An individual patient will demand and respond to differing approaches during his addicted career, and a decent service should be able to meet those changes and support what the patient is motivated for at that time. I absolutely agree that few, if anyone, approaching a service for the first time would say that they wanted a lifetime of servitude to a drug service, a doctor, a pharmacist and a rather boring drug – but evidence supports the practice of prescribing, at least at the outset.

True, prescribing may demotivate some who are so powerfully motivated that abstinence may have a decent chance at achieving durable abstinence, and in so doing may doom them to more time in treatment than might have been achievable. But there are many more patients

who are grateful for this period of stabilisation and see it as a necessary step before the final push for abstinence, which as we see all around us, is indeed achieved by many, and from within the same service.

Prescribing without the hope of eventual independence is philosophically bankrupt, and abstinence without the safety net of harm reduction when relapse occurs is dangerous – they need each other, so treatment services need to provide both, effectively and wholeheartedly.

Dr Gordon Morse, Clinical Lead, Turning Point Somerset

[1] *Network*, 22 April 2008, 'Why Are We Fighting', Gordon Morse. Online at www.smmgp.org.uk

Abstinence defined

The Birmingham University team is right to sharply differentiate between maintenance prescribing and abstinence in 'Different Roads'. The former is like taking an alcoholic off whisky and then buying him vodka for life at taxpayers' expense!

By recognising 'managed addiction' as 'non-abstinence', we are able to take a better look at what true abstinence is, and the dictionary tells us that it is 'the act of refraining (usually voluntarily) from the ingestion of some substance' – which allows various ways for an individual to achieve this state.

The first is the 'naturally abstinent state' into which 99 per cent of the population are born, and to which natural recovery, 'maturing out' and effective rehabilitation returns former addicts.

Then there are those, who with the support of fraternal organisations such as AA, NA and CA eventually make it through to self-sustained abstinence.

Next there is the group indicated by Professor David Clark, when he observed that 'Most people who recover from drugs problems do so on their own, without formal treatment', and he suggested that, to be effective, interventions should facilitate natural change processes.

Finally, there are those programmes which validate Clark, but which also recognise that there is a much larger group who are also capable of attaining relaxed unsupported abstinence for life – if they are trained in a workable method of recovery which they may then, of their own volition, apply to themselves and their condition.

But this is achieved only if drug usage is recognised and handled as a matter of personal choice and self-determined discipline rather than as a medical condition.

Success with hundreds of thousands of addicts over 42 years and across 43 countries demonstrates that the addict himself is the only person regularly capable of withdrawing and recovering himself from drug usage on a relaxed lifelong abstinence basis.

And the beauty of training an addict to get himself off drugs is that he carries that knowledge with him for the rest of his life and, even if he again relapses, he still has an effective recovery tool immediately to hand.

E. Kenneth Eckersley, CEO Addiction Recovery Training Services, former magistrate and retired justice of the peace.

A question of logic

The article 'Different Roads' made a number of interesting points but I have to question the logic of the statement that 'two prior episodes of formal treatment is actually associated with reduced likelihood of sustained abstinence' – surely this has to do with sampling bias. Is it not also the case that those who need repeated cancer treatment have more chance of dying of cancer; that is not to say that cancer treatment does not work.

Niall Scott, dual diagnosis development worker, North Shrewsbury CMHT

Of particular interest

The 19 May issue of *DDN* was particularly interesting, with several items which I would like to comment on.

Firstly, regarding the 'Different Roads' article: I would say that in practice, the roads are not so clear cut and may change as the person travels through treatment. So often, the priority is to help someone to stabilise their life first, so they can then make informed decisions about the long term. Initially, many people just want some decent help and cannot look further than that. Therefore the road may well be the same for many people whether they can detox – quickly, slowly, or never. I don't think it is helpful to polarise the debate into rigid extremes and paths set in stone.

Secondly, regarding the letter 'Choosing residential treatment' (page 8): I would like to point out that residential treatment centres have no control over the quality of treatment when people have left them, and so to devise a rating system based on long-term outcome is meaningless in this context. There are other measures, such as completion rates, waiting lists, patient satisfaction, and so on, which are better markers of quality.

Thirdly, I would like to congratulate and encourage Bri on his series of articles – I especially look forward to reading them. Frank personal experience, written in an easily readable form, is very helpful in understanding the people we see every day – and ourselves, and can definitely influence practice for the better.

Fourthly, and perhaps most contentiously, can we please have some scientific basis for treatments promoted in the magazine. I refer to 'A Polish Experience' (page 12) about auricular acupuncture which seemed to be promoting treatment involving 'detox points' and 'hepatitis C'. Now, I am aware

that there is evidence for auricular acupuncture in stimulant withdrawal, but this seems to make more widespread claims – and it would be very interesting to hear what evidence there is for them. I was especially intrigued by the plastic ear and the supposed areas relating to other parts of the body. What is the evidence for that?

It is good to have a magazine that can produce debate – and that is often how we learn – so, anyone for more debate?

Joss Bray, by email

Rehab Outcomes Project

The letter from Kenneth Eckersley (*DDN*, 19 May, page 8) about residential rehabilitation correctly highlights the importance of outcome data.

Although the publication of star ratings by CSCI (for England) is an important step forwards, CSCI and the other UK regulators are limited in their scope of interest to compliance with National Care Standards.

Care managers continue have very limited information about how rehabs compare and what they actually achieve for clients; this gravely undermines the effectiveness of this corner of the substance misuse field.

The Rehab Outcomes Project is under development to address this need. We aim to improve the effectiveness of residential rehabilitation in the UK by collating and sharing information about the outcome, effectiveness and quality of these important services.

The project is based on a pilot outcome-monitoring scheme run by the author in London several years ago. More information is available from the project website www.rehaboutcomesproject.info/ where you can register interest in the consultation or pilot later in the summer.

Richard Phillips, Rehab Outcomes Project

And finally...

I note with a mixture of incredulity and amusement Professor McKeganey's latest volley (*DDN*, 19 May, page 9) in what began as a debate over standards in the drug treatment workplace and how best to assure them. His intervention once again misses entirely the point I sought to make; however, I am content to yield to him the last public word he so clearly needs, while thanking him for the apology issued privately.

Sebastian Saville, executive director, Release

We welcome your letters

Please email letters to the editor, claire@cjwellings.com or post them to the *DDN* address on page 3. Letters may be edited for reasons of space or clarity – please limit length to 350 words.