

## **Response Paper 2**

### **Maintaining Abstinence As a Treatment of First Resort**

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I would like to begin my response to Jeff Ward's paper by thanking Barry Cullen and the organizers of this conference for providing me with the opportunity to speak about such an important topic. Addiction in all its forms continues to have a very, powerful and negative impact on Irish life. In fact, few in this audience would disagree with the statement that it is quite rare to find an Irish family that has not been negatively impacted by Addiction in one or another or its forms, although the form of Addiction most frequently mentioned is, of course, Alcohol Dependence.

I believe that Jeff Ward's paper makes a very strong case in favour of Methadone Maintenance for some. Although I do not believe that the situation here in Ireland is exactly the same as in Australia, the US or any other society, his point is quite clear: that methadone maintenance should be regarded a significant weapon in society's arsenal against the criminality, spread of infectious diseases and many other dangers usually associated with heroin addiction. On one level agree with his position. I believe that Methadone Maintenance can be a life saving resource for some of those deeply stuck in the advanced stages of heroin addiction and for whom a variety of drug free options have not been effective.

Those in this audience who are familiar with the treatment philosophy of Rutland Centre are well aware that we do not advocate the use of methadone or any other drug substitution therapy with our clients. We follow what has usually been referred to "the Minnesota Model" of treatment. In practice, there are various forms of the Minnesota Model and there are important differences between our approach and the approaches of other treatment programmes that are more closely aligned with the Hazelden Centre outside of Minneapolis. However, the Minnesota type programmes all advocate an abstinence-based, 12-step approach to treatment and recovery which focuses on a blend of various forms of therapy as well as education and information on addiction for both the addict and the concerned person. Our approach is considered spiritual, although in a very non-religious, non-denominational kind of way. Our clinical programme assists the entire family with recovery. Our modality engages clients in a very intense two therapy groups a day approach to recovery. Our programme emphasizes an invitation to the client to take that all important First Step towards changing their entire life. Primarily, we deal with the underlying hurts and losses that fuel the low self-esteem, the self-loathing, and the self-sabotage that exacerbates chemical misuse and moves it from experimentation into full-fledged addiction. And we get results! Rutland Centre is a truly special place that has opened up for many thousands of individuals the opportunity to change their lives forever.

As I begin to outline several points for this audience's reflection, I wish to state some obvious facts for your collective consideration:

1. Whilst it may be convenient and useful to use such terms as "abstinence-based" and "harm-reduction" approaches to treatment, the reality is that most of us still believe that eventual abstinence is the ultimate goal for all, or at least almost all, of our clients. In that sense, most of us can accurately call ourselves "abstinence oriented" in our philosophy of treatment as to where we eventually hope our clients will go, but we simply disagree whether it is preferable to use long-term use of methadone as a means towards that end. I also believe that in the professional world of Addiction Treatment,

few of us believe that until there is a true cure for addiction, which may or may not someday happen, the best any of us can do is to “reduce harm” and in that sense we are all on the side of “harm reduction”. We all want the same thing for our clients, which is freedom from the life-damaging ravages of chemical addiction.

2. Most of the individuals who are in trouble with chemical abuse today are not receiving any kind of professional treatment or support service from anyone. Obviously we have important differences of approach. Rather than argue and disagree about who has the better approach, I believe we must find more and more effective ways to reach out to the massive number of individuals who are not receiving any kind of professional support from anywhere. It has been estimated that the number of heroin addicts in Greater Dublin alone ranges from 13,000 to perhaps up to 20,000. And yet fewer than 8,000-9,000 are receiving direct therapeutic services in any given year. Most opiate addicts are not being served at all. Facts from the provincial towns and smaller cities around Ireland indicate that in such communities as Athlone, Carlow, and Mullingar the numbers of heroin addicts are no longer in the dozens, they are now in the hundreds. It is no longer accurate to talk about heroin addiction as a “Dublin problem” but rather as the national problem that it is truly becoming. I also contend that although our National Drugs Strategy splits off the “drug problem” from the “alcohol problem” the reality is that we have one of the highest levels of per capita alcohol intake in the world, and that the vast majority of individuals with Alcohol Addiction, Compulsive Gambling problems, Food/Internet/Shopping and other Addictions are also not being treated, stabilized or maintained on anything and are also not seeking or receiving professional services from anywhere.
3. Cocaine has joined ecstasy and amphetamines as a leading cause of concern in Drug Addiction circles around Ireland. On Friday 13th of September, I spent a very interesting but alarming couple of hours with close to 100 drugs counsellors and workers, mostly from Greater Dublin but also from elsewhere who are frightened by the a disturbing escalation in cocaine use in Ireland -most often in combination with Alcohol or Heroin or Methadone but sometimes as a primary source of chemical dependency. In fact, a recent UN study recently pointed out that Ireland ranks first in European the use of amphetamines and ecstasy and third in Europe(and quickly rising) for cocaine. I contend that the core issue of chemical abuse and Addiction in Irish society is not whether to use methadone less often or more often, it is how to address the staggering problem of substance misuse on many, many levels. I believe that Alcohol misuse is at the core of Ireland’s drug problem and that until there is a major change of consciousness in Irish Society we are going to continue to be “A Nation in Denial”. We cannot correct the problem of chemical abuse with a chemical and this has never been more apparent than with the recent rise of cocaine in Irish Society.

But what about Methadone? Is it a chemical that has often been maligned and rarely appreciated by those of us on the drug-free side of the spectrum? Perhaps!

Studies are difficult. Although I have great respect for Jeff Ward’s scholarly review of the literature, I am left wondering if what might be the result if we compare a large enough number of individuals who have completed a comprehensive drug treatment and social rehab approach with those who have stayed on methadone only.

If I were a sceptic, and I am glad that I am not, I would be saying that many of Jeff Ward’s comments are about studies conducted not only in another country but at a another time. Sometimes the apparent “failure” of individuals to remain abstinent in a so-called drug free treatment modality is based on data for those who have successfully completed detox only and not on those who have undergone a comprehensive drug free treatment experience. One wonders how often have individuals received the kind of support that individuals truly locked

into “deep combat” with Addiction truly require. An example of what I mean is this: Over the past few years Soilse, a social drug rehab programme in the North Inner City of Dublin has joined up with Rutland Centre in what is known simply as the “Rutland-Soilse” Partnership. In the first two years of operation, two follow-up studies were conducted by outside research specialists. In the first of these, 7 out of 10 former residential clients who not only completed our 6 week residential programme, but who also completed Soilse’s 4 month day programme were both clean and sober in every way.

The second year study indicated that 9 out of 10 who completed both sides of the partnership programme were doing well with at least 6 months’ clean-sober time as at the date of the follow-up study. We are very grateful to Soilse for the outstanding rehabilitation services that they provide and also to the Northern Area.

Health Board for the funding that they provide for this highly successful programme. But I would also acknowledge that the numbers involved are quite small. We need more data from more efforts of such a comprehensive approach to be able to be more convincing of the efficacy of such an approach.

But I am not a sceptic. What I like to think of myself as is, instead, a realist who understands that heroin dependency is a vicious fact of modern life. None of us can afford to be on a crusade to condemn and criticize our colleagues who have a somewhat different set of beliefs about what works best for most. But at the same time I believe we must look at how the methadone programme works in this country and find better ways to manage what is going on. I am very concerned that we look at some of the international data, we then decide that since methadone works pretty well with certain population groups in several other countries it is therefore the “treatment of choice” for almost everyone in trouble with heroin in this country.

This is faulty logic. All too often I have sat in my office with a prospective client who tells me that the physician with whom they consulted told them that methadone is “just like insulin for a diabetic” and that they will probably need to be on methadone for the rest of their lives. This may or may not be what the physician actually said but it is what the client is hearing. It is hugely difficult in this country for all but a relatively few to get successfully detoxed off methadone once one has started on methadone. My greatest concern is that individuals in this country are not provided with a well-informed choice of a drug-free option vs. methadone maintenance with a detailed explanation of the advantages and disadvantages of each. This is wrong! The clients who tell me that Methadone is nothing short of “state sponsored addiction” are sometimes tell me that they are asking for the choice to go drug-free and that the response is that they are not ready. This is wrong! Because many chronic heroin addicts do function better on higher doses of methadone (80mg-120mg per day), it is therefore assumed that most heroin addicts benefit from these higher dose amounts and we then begin a medication protocol. This is wrong! We fund GP’s and others to maintain heroin addicts but we do not fund more than a handful of GP’s to detox heroin addicts. This is unfair and unbalanced. We know that individuals who attend counselling on a regular basis in combination with receiving other therapeutic services have a higher success rate yet we do not have enough counsellors trained in this society to do the work that needs to be done.

This is ineffective public policy. In some settings we have qualified counsellors available to see clients but we tolerate clients not keeping their counselling appointments and other commitments. This is enabling behaviour and it is not in the client’s best interests. This may be “user-friendly” but it is not effective management of client care.

It is very easy to stand back and criticize and I hope that is not what I am doing here today. Solutions are very difficult to create. I believe that addiction is bigger than I am. I believe that clients are courageous when they undertake the work of recovery. It saddens me when individuals who have done great work relapse and, despite our outstanding work at the Rutland Centre, relapse happens more often than I would like to admit.

What I am asking for today in the context of my response to Jeff Ward's paper, is that we honour what our clients both want and need. They need informed choices and this is not possible in a society where there is not enough funding or training resources for successfully addressing the reality of opiate addiction in Ireland today. Most of our residential clients at the Rutland Centre have huge hurts and losses in their backgrounds. These must be addressed if we are to have successful long-term outcomes. The "hole in the soul" is very real and it needs to be dealt with if we wish to see major changes occur in the lives of our young people. We cannot medicate the problem away. Methadone maintenance does help reduce the transmission of HIV; when it works well, methadone maintenance does help reduce crime in the streets; methadone maintenance does stabilize some people well enough so that they can sustain long term employment and establish meaningful long-term relationships. Methadone maintenance is a strategic approach of major significance and has its benefits. But while the "harm reduction" approach does help, it sometimes reduces harm for society as a whole and not necessarily for every individual addict involved. Methadone is still an opiate substance with addictive properties more compelling than heroin. This must not be ignored either.

Methadone maintenance does not address the reality of cocaine dependence, which is looking very strong as the next best "drug of choice" among young addicts in this city. Methadone maintenance does not stop individuals from topping up with prescription medication such as benzos, significant quantities of alcohol, black market methadone and heroin and cannabis. Methadone maintenance does not address the culture of poverty and joblessness and hopelessness in a society where we apparently need to import workers for our expanding economy whilst we continue to ignore the emotional and educational and vocational needs of so many young people in the impoverished areas of this city. Methadone has some advantages but it also has some major disadvantages.

Clients, particularly young opiate addicts, are not getting enough of what they need growing up. They do not need us to replicate that reality by not giving them enough of what they need in treatment and in recovery.

In closing I would like to offer support to my colleagues in the drugs/AIDS service who work hard to bring encouragement and respect to so many young people (and those not so young) who have grown up broken in what I believe is an alcohol soaked addicted society. I would like to challenge all decision makers with limited resources, please create ways to train more counsellors to meet the needs of addicts and to give more power and influence to the counsellor community in the overall management of the drug treatment services. Please look at the successes of drug free approaches and make sure that every drug addict in Irish Society has the right to choose a drug-free option. Please consider calling for the drug-free approach as a the treatment of first resort instead of immediately accepting long term methadone maintenance under the mistaken belief that the individual in question is probably not ready to be abstinent anyway. Profound change can and does happen all the time. We must honour the needs of many of all our clients and provide them the best of what we collectively have to offer.

Thank you.