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# Addressing violence in methadone maintenance treatment

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*Summary*

Violence is a core public health issue which is linked to substance misuse in complex and interactive ways. Qualitative data on 220 violent episodes was collected over a three year period from service users and staff at Dublin methadone clinics. Inductive analysis of the data led to a typology of violent events, which may help to enhance clinical and social responses to the problem. Witnessed clinic episodes were interpreted as consequences of disturbed individual states or traits, or in terms of immediate situational conflict. Client narratives were construed as illustrations of family violence, local feuds, delinquency, dealing, retribution and abuse.
A variety of pertinent clinical and organisational solutions are put forward in the context of a necessary community development and social inclusion process.

Key Words: Violence - Methadone Maintenance

## Introduction

Economic growth in the Republic of Ireland has reached unprecedented levels in recent years, but this development is accompanied by widening social and health inequalities. Significant new problems of multisubstance misuse continue to be identified, with an estimated 12-15000 regular heroin users in Dublin. As so often elsewhere [1,7], the current epidemic of heroin addiction in Ireland is rooted in problems of social

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exclusion [6], with many opiate addicts interacting with the criminal justice and health-care systems in a chaotic and hazardous manner. Harm reduction policies have been implemented in Dublin for the past decade, and a new network of public methadone maintenance clinics has attracted around 4000 clients. In addition to viral containment and prevention of overdose, the service is intended to assist service users in facing the challenges of social reintegration, childcare, housing and employment [33]. The clinics are situated in deprived localities and have provided a service to a large backlog of opiate and multisubstance addicts with a wide spectrum of medicosocial problems. Several thousand additional cases are being treated in the ordinary general practice setting, but the bulk of the caseload remains in the public clinics.

Some of the most serious clinical and organizational issues for the new HIV and Addictions Service have involved the management of violence. Interpersonal, collective and self-directed violence is a major public health issue worldwide [34], and is prevalent in socially excluded communities, [9]. Violence has a complex, interactive relationship with substance misuse and mental health, so that initiatives to prevent violence, and to help clients to cope with the aftermath of violence are an important part of harm reduction. There is currently a lack of specific focus on the issue in opiate substitution treatment literature. The purpose of this study was to analyse violent episodes and violence narratives at Dublin methadone clinics and to enable the identification of improved care pathways for individuals, families and communities.

***Reflexive research***

Human services professionals need to establish the basis for safe, effective and ethical actions. Practical reasoning enables us to make more prudent decisions in the light of a richer understanding of context [17]. Practitioner inquiry has an explicitly reflexive ethos, where research questions spring from the problems of practitioners, and practice changes to reflect the insights of research. [31]. The inner-city methadone clinic setting epitomizes the “swampy lowland” described by Schon [29], where “situations are confusing messes incapable of technical solution”.

Research aims to establish what is true, and the validity of social research findings can be established in many ways [10]. Investigation of this type is concerned with the generation of context-centred knowledge which aims to help in solving urgent public health problems in the field [14]. The recording and analysis represent the efforts and spontaneous constructs of a practitioner attempting to make immediate or subsequent sense of events witnessed or accounts offered in the course of clinical work. As Schon [29] has said, “The sense he makes of the situation must include his own contribution to it”. Violence was considered as a material phenomenon or as a kind of language, with a wide range of practical social expression and a varying subjective personal meaning for both victim and perpetrator [12]. In any case, the common factor was that the episode was perceived as disturbing, frightening or upsetting enough to be reported and recorded at the clinic.

## Methods

Descriptive data on 220 violent incidents was collected in the course of some 17,000 consultations with 270 service users at five Dublin methadone clinics over a three-year period. Additional corroborating information was recorded in field notes, and all information was incorporated into a daily workplace journal. Many episodes and client narratives were subject to review within a multidisciplinary team which included medical, psychiatric, pharmacy, nursing and counselling staff. Sequential consultations with the same individual increased the depth of the information received and it was sometimes possible to obtain a triangulating version of the events from several service users or colleagues. Some on-site incidents were witnessed by the author in a participant observer capacity.

The qualitative database, totalling 610,000 words, provides the basis for an analysis which resembles incident monitoring [5], but relies on an interpretation of free text accounts. The record suffers from the lack of a taped verbatim record of the client narratives, and from the practical limitations of recording within a busy caseload. There is a selectivity in the information presented, since the clinical interview tends to produce a functional discourse [3], with limited reporting of incidents perpetrated by the service user. Violence is a sensitive research topic [19] and a high priority was given to safety and client confidentiality, so that there were some prudential and ethical constraints on the process of obtaining corroborating information.

## Results

### *Witnessed violence*

Violence was regularly witnessed at the clinics when incidents or disruptions to the service occurred. These were divided into episodes where there was an immediate source of conflict, and events which seemed to reflect a more generalized disturbance of the person.

### Acute conflict situations

Certain episodes appeared to have immediate situational roots, including disputes with staff over prescriptions, takeaway doses or allegations of dealing on the premises. These episodes sometimes included threats of deliberate self-harm, of arson attack on the clinic, or physical or sexual assault. Some incidents included the throwing of furniture, the kicking of doors or assault on personnel. Problems also arose over apparently drug-related disputes on the premises, with troubled social relations among some service users. The necessity to queue for dispensing within physically cramped and strictly time-limited conditions probably determined a closer degree of interaction than some service users might have chosen. Incidents of this type tended to escalate rapidly from hostile verbal exchanges to physical assault or threat of attack with knife or blunt object. On one occasion a firearm was discharged in the vicinity of a mobile methadone dispensary.

**Disturbed states**

Some incidents may have reflected acutely disordered psychological states, rendering people vulnerable to external disturbance of any kind. The most obvious basis was intoxication or withdrawal, with addicts urgently seeking a methadone supply. Concurrent misuse of cocaine could be associated with agitation, irritability and disordered behaviour. Benzodiazepine use was prevalent, with more than half of all attenders testing positive for the drugs at urinalysis. Disinhibition and aggression was witnessed in clients who were intoxicated, and could present an acute dilemma for dispensing staff, involving risks of overdosing the client or personal assault.

*…E had reacted very angrily when asked to provide a urine sample and threatened to break the staff member's jaw…*

The caseload also included persons with psychotic illness, mood disorder, post-traumatic stress disorder and cognitive deficit. These "dual diagnosis" type problems were either a cause or consequence of substance misuse, or they were deemed to exist on an independent basis. Adequate investigation and treatment often required a lengthy and risky engagement with the service, and consistent reduction of assaultiveness was not always achieved.

*…F had been asked to see his doctor before being dispensed. He lost his temper, and punched the wall, resulting in a fracture to the hand...*

Clinic staff were obliged to develop a sharp awareness of individual psychological states and traits, as well as a range of "acting out" or "borderline-type" behaviours. Displays of violence might have been learned in settings such as prisons, where many service users had spent long periods. The relationship between substance misuse and mood disorder was difficult to assess in the poverty context, where there were many situational triggers for fear and anxiety. Community psychiatric services are poorly resourced in Dublin, and it was often difficult to offer any asylum, or place of safety, to very disturbed addicts.

*…. T became very animated, and in colourful language, punctuated with bitter references to "psychos", "zombies", and emasculating psychiatric medications, he described a vista in which the Gardai (police) had conspired to bring drugs into the area, thereby causing his addiction, and subsequently to scapegoat his family…*

***Reported Violence***

Many violent incidents were reported by service users to have occurred outside the clinic setting. Such narratives could be typed very broadly into intimate violence, where both parties are already involved in a kin relationship, and violence among persons who interacted otherwise in the local environment.

Domestic violence was regularly reported, in a wide variety of forms and contexts. Both male and female clients reported batterings at the hands of parents or partners, and sibling conflict sometimes erupted into knife assaults, with obvious and severe injuries later demonstrated at the clinic. Several female clients were raped or very seri-

ously injured in domestic violence, and suspicious injuries to infants were reported. A number of domestic homicides, involving clients or their immediate relatives as victims or perpetrators, were reported during the study period.

Very violent assaults with knives and blunt instruments were reported to have been carried out by both men and women outside the home. Impulsive assaults by using or drinking companions were common. Some had serious outcome by knife wound, head injury or needlestick. Kickings and beatings of service users by intoxicated teenage gangs resulted in concussion, severe facial injuries and loss of teeth. Disputes between neighbours resulted in assault, leading to a range of harms, including life-threatening head injuries, and death from stab wounds. Rape was reported by both men and women and was a particular hazard of street sex work. A homicide was reported in the context of income-generating activity.

**Extended patterns of violence**

Many individual episodes of violence could be regarded as part of deeply rooted social structures and processes. These were categorised provisionally as follows:

* family dysfunction
* feuds
* delinquency
* deals
* retribution
* abuse.

**Family dysfunction and homelessness**

Many cycles of intimate violence were reported to be chronic, with the same individuals involved in repeated assaults as perpetrators, victims or both .

The dynamics were highly complex and related to the substance misuse of one or more parties. The stereotypical violent alcoholic father was strongly reflected in the data, but violence could be perpetrated by any member of the kin group. There seemed no clear dividing line between traditional, alcohol-associated domestic violence and oppressive family relations in the context of drug dealing and crime.

Many female clients reported life-long patterns of domestic violence at the hands of intoxicated father, stepfather or brothers, with verbal abuse and violence sometimes perpetrated by a series of male authority figures. Others reported beatings with blunt instruments, stabbings and burnings with cigarettes at the hands of jealous, "paranoid" or possessive partners. Fraught domestic encounters, involving a threat of knife assault or self-slashing, arose in situations where parents or siblings were seeking to access another family member's supply of benzodiazepine tranquilisers.

*…C displayed a gash on his forearm, allegedly inflicted with a kitchen knife by his brother, who he said had then threatened to jump from the balcony and kill himself…*

Serial assaults were reported, in which parents, siblings or partners beat, stabbed or shot other family members in retaliation for assaults committed on a client. Female

siblings were also reported to be assaultive to clients on occasion, while some mothers of clients were said to carry blunt instruments for purposes of self-defence. Other mothers were reported to have collapsed during violent domestic rows, perhaps as part of a deliberate strategy to call for emergency services.

*…..Mrs B told me how she has lived for forty years with a man who regularly "pulls a knife" on her when he in drinking. She has seen her three sons developing opiate addiction, and manages one schizophrenic son at home, borrowing some of the methadone maintenance from her other son every morning, "to pacify him"…*

The incidents reflect the interdependencies and enmeshment involved where many members of a diffuse and extended clan were housed in proximity, with little prospect of independent housing for many younger persons. The prevalence of single-parenthood, teenage pregnancy, and family instability resulted in some highly chaotic interactions within the home setting.

*…H has had a violent father and later a violent partner, and has a hyperactive three–year old son She reported that the family home had been set on fire accidentally by her child, and her Da (father) beat her up in a rage afterwards.*

Economic change in Dublin has led to an increase in the number of persons who are homeless or have no fixed abode, and some service users revolved between prison, hospital and hostel. Homelessness was related in a complex, recursive way to family dysfunction and to substance misuse. Kin violence often took place in public, where it was liable to interact with processes of a different type, and the distinction between domestic and street violence was blurred in these circumstances. Very violent assaults, including throat slashings and fatal beatings were reported to have occurred to homeless clients or siblings. Some were said to have been carried out by persons with well-known violent propensities, in the dynamic and unstable world of hostels and traveller (gypsy) halting sites. Some homeless clients were suffering from cognitive deficit, psychotic illness or severe alcoholism, often associated with repeated partner assault.

*…R had a deep laceration on her shin, which she said resulted from a "belt (blow) from her partner with the back of a hatchet".*

**Neighbourhood feuds**

The Dublin slum environment can be dangerous, although the use of firearms is relatively unusual. Many public spaces are poorly designed, badly lit and filthy, and families tend to retreat behind a solidly barred front door, leaving the local environment to the depradations of teenage gangs and street drinkers. Quarrels between neighbours were commonly reported, and displays of violence, or at least the maintenance of an intimidating appearance, may be functional in a challenging local milieu. Feuds, vendettas or extended conflicts, within and without the extended family structure, were a notable feature of the reports, and were sometimes pursued in the clinic setting. They were likely to be associated with family dysfunction, lack of negotiating skills, or traumatic experiences. Many episodes were clearly triggered or exacerbated by alcohol.

*... there is "bad blood" (hatred) between her and Mrs B, who will "never forgive*

*her" because "her daughter is over in England with liver damage"...*

Many feuds were said to begin or to be continued in the main prison, which has major problems of injecting and drug misuse, with a substantial proportion of inmates in protective custody. Neighbourhood feuds among females were also reported, and included assaults with knives and blunt instruments following disputes around alleged infidelity or child neglect.

Dublin methadone clients are a weak social group, competing for resources with other marginal participants, including Irish travellers, new immigrants, or disabled persons. The traditional "psycho" stigma associated with mental illness remains strong among Ireland's poor, and community resettlement of discharged long-term patients has led to tensions in some neighbourhoods. Mutual recrimination, labelling and projection could erupt into open violence, with stone throwing, arson and destruction of motor vehicles or other property. Clients reported lucky escapes from shotgun blasts and vehicles driven at speed towards a group. Accidental homicides, such as the death of a baby in a petrol-bomb attack, and the machete killing of a sibling were said by clients to have arisen as a result of feuds.

*…A was burned out of home together with his 9 siblings and mother. He explained that " my windows had been put in (smashed), my mother's windows had been put in, and my brother was shot through the window of my sister-in-law's house"…*

**Delinquency**

The clinics were located in marginalized neighbourhoods, with endemic problems of vandalism, petty crime and public order. Car theft and street racing was common, with intoxicated youths engaging in public displays of bravado, leading to a toll of death and disability

*…some of the group stole a car, and hit a wall, with one dead and another injured, so that the client now fears that her family home will be smashed up, as " they do that as mark of respect for the dead youth".*

Clients described teenage group intoxication rituals which were conducted in stairwells, hallways or other public spaces, where sanitary facilities were usually absent and nuisance was inevitable. Some service users described overdose deaths of former associates. Income generation usually involved shoplifting, perhaps meeting the need for affordable consumer goods in a locality where incomes were generally low, so that an economic niche tended to be established for the perpetrators. Stealing from neighbours or kin, however, was a violation of group norms which tended to attract bitter condemnation, and was reported to have led to violent confrontation and assault. Adolescent sexual activities were naturally clandestine and probably involved violations of legal norms and human rights in such unprotected environments.

Disturbed and addicted adolescents were regularly reported among the siblings, children, relatives and neighbours of clinic clients. Some families were enduring combinations of delinquent, drug-related and domestic violence, and were regularly experiencing multiple types of violence risk.

*…Mrs T had discovered her teenage son in the kitchen with a shotgun, threatening to "blow his head off". She asked her eldest son, who has current drug-related firearms charges, to dispose of the weapon. The teenager was so distressed that she justified in continuing to treat him with some of her own Valium supply…*

**Dealing and debt collection**

There is little separation of drugs markets in Dublin, with the result that methadone clients, who generally continue to use hashish, were also offered heroin by the same suppliers. Violent methods of debt collection were reported by service users.

*... M demonstrated the injuries meted out to him in the punishment attack over a small drug debt. These included lacerations to face, hand and scalp necessitating 80 sutures, fractured jaw, nine teeth knocked out, and bruising to ribs, back and flanks...*

Other forms of debt enforcement included burning with cigarettes, assaults with iron bars, punishment shootings, and driving-over by motor vehicle. Some assaults were reported to have been perpetrated in the family home, by intruders wielding iron bars, and resulting in fractures. Some victims had been warned not to attend for emergency hospital treatment, under pain of further assault. Contract assaults, carried out on the basis of cash payment, were described. Several clients who were involved as state witnesses in the prosecution of perpetrators reported intimidation, reporting that they were afraid to leave their homes. Other service users had siblings or relatives who were charged with such assaults and suffered an acute and painful conflict of loyalties.

**Retribution and street justice**

A tendency towards street justice, paramilitarism, or community defence is seen in poorer communities in Ireland. This may reflect the persistence of local traditions or the failure to vindicate legal and constitutional norms at the base of the society. Sinn Fein, a constitutional political party with close links to the IRA, is active in many of Dublin's poorer communities, and remains one of the tacit driving forces behind the development of drug treatment services in Ireland [8].

Most retribution reported by clients was spontaneous, piecemeal, and connected to the feuds described earlier. Some traveller communities still tended to resort to displays of force and other extralegal means for settlement of disputes, and traveller clients described shootings and group confrontations at halting sites. Local community leaders sometimes convened neighbourhood meetings to address issues of public order, and clients reported that siblings had been "named and shamed" at such events.

**Abuse and self harm**

Death by suicide and accident were part of the violent backdrop to clinic life, and tragic incidents were regularly reported by distressed clients. Deaths from falls or hanging were reported to have caused great distress to family, neighbours and other witnesses.

*…T was upset at the suicide of his neighbour who threw herself from the tower block.*

*This resonated for him with his own father's death by inhalation of vomit…*

Suicide was reported among siblings and extended families of clients, and it was often difficult to establish the boundary between adjustment reactions to hopeless life circumstances and the course of a depressive illness.

*…S told me about E, who took his own life last week. Out of home at age 13, in and out of hostels and jail, under threat of retribution for anti-social behaviour and he had driven a car into a wall…*

Issues of sex abuse were an important trigger for self or other directed violence, and intense stigmatization is experienced by both victims and perpetrators. In situations where the father of the family was reported to have been subjected to severe beatings in childhood, it was sometimes difficult even to begin a dialogue around reasonable norms of domestic behaviour.

*… his father physically and sexually abused them all, and was later murdered himself. His brother had served life imprisonment for a separate murder, and he himself had been very violent when he drank a lot...*

Some clients reported abusive experiences at the hands of staff in statutory care institutions, where a number of scandals are still in the process of discovery. These adverse experiences may have established a collective tendency towards immediate gratification, a readiness to resort to aggression, or a fatalistic victimhood. In the most severe cases, it was possible to discern intergenerational, individual, family and community processes which found their expression in entrenched substance misuse and disorders of personality.

*…. her mother is a schizophrenic, and has been in and out of hospital for the past 30 years. She had three younger brothers, one a heroin addict, who jumped to his death, a second who died of a heroin overdose, and a third is a heroin addict with dual diagnosis, who is in prison...*

## Discussion

### *Clinical implications*

Violence is a practical human services issue, with consequences described in dedicated studies [35]. There is a need in methadone treatment services for greater recognition of violence risks, and for attenuation of the most dangerous phenomena at the individual and small group level. Prevention demands a thorough understanding of process, and a practice which is informed by existential theory [31]. This is very different from simple repression, or "zero tolerance", which tends to displace violence to hidden, more vulnerable populations. Barrings or refusals of service are a necessary but inadequate response to dangerously challenging behaviour, which ultimately requires a coherent system of case management and forensic support.

The principles of effective methadone maintenance have been set out very clearly [33], and successful therapeutic alliances are built on negotiation and mutual respect. Substitution and treatment services must be run in an efficient and humane way, with

due regard for the time and the sensitivities of service users. Preservation of life and limb should be central to any meaningful care plan, and should take precedence always over issues of simple substance misuse. Training can enable staff to cope more safely with incidents of violence, and clinical staff need the necessary autonomy to negotiate an effective and acceptable treatment package with service users. Arbitrary dosing limits, blanket bans on benzodiazepine prescribing or involuntary methadone reductions for illicit drug use are likely to be counterproductive. Dose supervision is a crucial form of support for persons who are vulnerable, homeless or highly unstable, but controls based on supervised urinalysis may be resented, especially by intoxicated or paranoid clients.

Site safety issues may be worsened by increasing reliance on impersonal or technological security solutions and a therapeutic alliance is critical. Frontline addictions work is a kind of "street practice" [18], where mental health supports must be made both physically and psychologically available to confused and alienated persons. Adjustment disorders may not be seen as "real" or organic forms of mental illness, but they can have lethal consequences, and may require urgent management on a preventive basis. Stabilization of substance misuse is often frustrated by factors such as adverse peer and family influences, imprisonment, treatment dropout, or ongoing intoxication. Diagnoses of personality disorder are liable to distortion by social and cultural factors, and the designation carries unfortunate connotations of hopelessness and untreatability. Decisions to withdraw treatment need very careful consideration [20], as they may be associated with very much increased risks. This is especially true in the case of the most troubled and dysfunctional persons, who are likely to persist in challenging behaviours and recalcitrant intoxication.

Recognizing family process can help to ensure that treatment goals are negotiated in a manner which recognizes the contingencies of the client lifeworld. Problems of addiction and violence are widespread in deprived comunities, and the skills of motivational interviewing and community reinforcement are central to primary care [25]. A partnership approach involving families and significant others can deliver an enhanced treatment effect, and can help to ameliorate frustration or abuse within the domestic environment. Women and children may be vulnerable to lethal harm from an addicted partner, and treatment should always be conducted with an awareness of the potential for violent displacement of any proposed sanction.

Most service users need a range of psychological and social services, but interprofessional or interagency co-operation may be problematic. Difficult clients may be referred on repeatedly from one crisis setting to another, with no real ownership of the core issues. Methadone treatment practitioners and managers need to develop good liasion with voluntary and statutory colleagues if we wish to minimize assaults, litigation or burnout. Substitution treatment many not be understood outside dedicated treatment settings, and repeated explanation is necessary for continuity of care. Supervision of temporary accommodation is vital in order to reduce the risks of intoxication, theft, or feuding, and hostel staff need training in mental health and addiction issues.

***Understanding the treatment context***

Although good casework is vital, it is important to be realistic about the limitations of individual and family therapy. Community development work is essential in bringing peace and stability to troubled neighbourhoods [22], and, with due regard for the service user's right to confidentiality, voluntary agencies need to be included in the communication loop. Community leaders can assist in empowering families, maximising health and social gain, and mitigating nuisance around local dealing scenes. Clinical staff have much to gain from contact with community workers, and can avail of existing social networks to reinforce the work of stabilization. Feuds and retribution may well diminish in a climate of positive communication, providing opportunities to build confidence in the use of more rational means of conflict resolution. Empowered clients and families are less likely to fall victim to moneylenders or other violent criminal elements, and clinic staff are more likely to receive local support in facing up to intimidation.

Social psychological and cultural theories of addiction, including considerations of drug, set and setting [23,32,36], are essential to a situated analysis of the cases presenting at methadone clinics. An understanding of interpersonal processes and group dynamics allows us to appreciate the role of honour and shame in the maintenance of a viable individual and collective identity. The sociology and social psychology of family function and dysfunction can help in analysing intimate violence, while theories of delinquency, gang formation and social deviance can assist in understanding "street" violence. The youth who shuns a dysfunctional or violent home is likely to encounter a set of peers in the neighbourhood and to share their problems of boredom, anomie and poverty [16]. Adolescent mental health problems, including ADHD, learning disability and depression could remain untreated and interact with other sources of problematic behaviour [2]. Existential theory is useful in constructing situated explanations of risk-taking and self-harm [26,31].

Problems of family solidarity, community integration and economic survival tend to generate sets of competing local norms, where peace is established on a small scale in ways which can lead to problems at a higher level of social aggregation [30]. Research which explicates the socioeconomic and psychosocial processes involved in inner-city neighbourhoods, the workings of the informal economy, and the drugs market [15], can assist practitioners in understanding the background to ghetto violence. The tripartite framework of drug-induced, drug-seeking, and drug-dealing violence is useful [13]. Drug dealing and the resale of stolen goods are important sectors of the informal economy, and many opiate addicts engage in small scale trading to sustain the habit [24]. In situations where there is little opportunity for recourse to orthodox legal mechanisms, conflict over property rights is often settled informally by means of inducements, threats, or displays of force. These accounts can demonstrate both the contingencies which lead to drug-related conflict, and the existential position of the actors engaged in the struggle for "euphoria, meaning and identity" [4].

Addiction processes often seem rooted in deep social structures of social exclusion,

domestic abuse and institutional cruelty [28]. A reliance on imprisonment may entrench marginalization and risk-taking, and the volume of sentenced offenders is likely to prevent necessary rehabilitation work from taking place. Harm reduction requires a coherent and consistent approach to the international regulation of psychoactive substance use, and alcohol regulation is increasingly critical. Many interlinked public health hazards are related to gross inequalities and defects in educational, economic and political systems. These can produce settings of generalized social pathology [21], where violent struggle over basic resources is almost inevitable [11]. Significant modification of the risk environment [27] will require movement towards a more inclusive model of economic and social organization.

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