Community treatment of drug misuse: 
more than methadone

Does the widespread use of methadone achieve the right balance between treatment of the individual and management of a public health problem? The use of methadone as a substitution agent in heroin dependency has dominated treatment of drug misuse in recent years. This approach has had considerable success but, as a result, other treatment options, and treatment for users of other illicit drugs, have been neglected.

This book draws on the author’s direct clinical experience and makes use of findings from Europe, North America and Australia to provide a comprehensive and detailed guide to service provision and treatment for drug misuse, including methadone and alternative opiate substitutes, detoxification methods, nal-trexone and relapse prevention, and possible approaches with nonopiate users. There is a particular emphasis on social factors in drug misuse and dependency, and the consequent treatment issues and practical difficulties, and case studies are used throughout.

Combining a highly practical approach with a strong research base, this book will be an essential resource for psychiatrists and other professionals involved in the management of drug misuse.

nicholas seivewright is Consultant Psychiatrist in Substance Misuse, Community Health Sheffield NHS Trust. One of the UK’s leading specialists in drug misuse, he has published widely on personality disorders, psychopharmacology and drug misuse, and has coedited an international series on addictions in The Lancet.
Community treatment of drug misuse: more than methadone

NICHOLAS SEIVEWRIGHT
Consultant Psychiatrist in Substance Misuse, Community Health Sheffield NHS Trust
### Contents

*Foreword by Professor John Strang* ix  
*Preface and acknowledgements* xi  

**Introduction: community treatment in context** 1  
Drug misuse as a social problem 3  
Risk factors for drug misuse 4  
The role of treatment 6  
Inpatient and residential treatment 8  
Summary 13  

### Part I Treatments

1 **Methadone maintenance: a medical treatment for social reasons?** 17  
   Introduction 17  
   The term ‘methadone maintenance’ 18  
   Formal methadone maintenance programmes 19  
   Other long-term methadone prescribing 20  
   The nature of methadone treatment 22  
   Effectiveness of methadone 29  
   Associated counselling 33  
   Practical management 35  
   Other forms of methadone, including injectable 43  
   Summary 46  

2 **More than methadone? The case for other substitute drugs** 49  
   Introduction 49  
   Diamorphine 50  
   Dipipanone (Diconal) 55  
   Cyclimorphine 56  
   Morphine 57  
   Issues in prescribing euphoriant opioids 59  
   Levo-alpha-acetylmethadol (LAAM) 61
vi Contents

Buprenorphine 62
Dihydrocodeine 64
Amphetamines 65
Benzodiazepines 70
Summary 79

3 Achieving detoxification and abstinence 82
Introduction 82
Quick detoxifications from heroin 83
Clonidine 88
Methadone 88
Treatment in pregnancy 99
Buprenorphine 103
Inpatient treatment 104
Other influences on choice of detoxification method 106
Treatment of minor opioid misuse 106
Relapse prevention 107
Summary 115

4 Treatment of nonopiate misuse 118
Introduction 118
Cocaine 119
Amphetamine 128
Methylenedioxymethamphetamine (MDMA, ‘ecstasy’) 132
Benzodiazepines 135
Cyclizine 138
Hallucinogens 139
Steroids 140
Volatile substances 140
Cannabis 141
Alcohol 143
Nicotine 145
Summary 148

Part II Providing clinical services

5 Community drug services 153
Introduction 153
Historical development 153
Contents

Changes in emphasis 155
Local provision 158
Drug counselling 164
Summary 165

6 Treatment of drug misuse in primary care 167
Introduction 167
Problems 167
Levels of interest 169
Positive treatment approaches 171
Summary 174

7 Balancing security and accessibility 176
Introduction 176
The changing policy picture 177
Drug misuse deaths 180
Implications for services 184
Summary 188

8 Dual diagnosis – drug misuse and psychiatric disorder 190
Introduction 190
Mental disorders in drug misusers 191
Drug misuse in the severely mentally ill 196
Summary 202

Epilogue Future directions 204
The scope of treatment 204
Opioid substitution 205
Security of treatment 206
Evidence-based practice 207
Stimulant misuse 208
Hepatitis C 209
Detoxification 210
Child protection 210

Appendix 1 Protocols for quick detoxification from heroin 212
Appendix 2 Opioid equivalent dosages 215
Glossary 216
References 219
Index 241
Dr Seivewright has produced an excellent handbook on the community treatment of drug misuse. Essentially, his book is a workshop manual for the practitioner faced with any one of the many challenges which may confront the medical or nonmedical drug worker in the UK. Just as a car workshop manual can guide both the novice and the more experienced mechanic through tasks ranging from the change of a lightbulb through to a complete engine re-fit, so Dr Seivewright’s book can guide the novice or experienced drug worker through tasks as varied as dose assessment to the organization of integrated service provision across primary and secondary care. Dr Seivewright is excellently well suited to prepare this book, bringing, on the one hand, the experience and wisdom of a battle-scarred clinician who has already worked for many years in charge of drug services in the UK and, on the other hand, the discipline and critical scrutiny of the academic in his search and analysis of the available international evidence for the treatments he describes.

More than Methadone. As the sub-title of the book indicates, the challenge and responsibility of better community treatment of drug misuse involves much more than methadone. Whilst parts of the book deal with ways of optimizing methadone treatment itself, other important sections deal with other aspects of a comprehensive holistic approach to care of the heterogeneous population who comprise the treatment population of today’s drug services. When methadone is prescribed, there are many different ways in which the drug may be used to assist recovery. Even within a particular treatment modality such as methadone maintenance, the treatment philosophy which the clinician and the patient/client espouse will vary greatly from one country to another, and also from one agency to the next – consider, for example, the sharply different ways in which methadone is being employed in either the ‘medical model’ or the ‘substitution model’ explored by Dr Seivewright on page 22 and thereafter. And how should one bear in mind the complicating factor of concurrent use of other drugs – either as an additional complicating aspect of the original presenting problem, or as one of the necessary ongoing outcome measures during the course of treatment. There is then
the enormously important consideration of the context within which methadone might be prescribed. The drug may be the same, but there is a world of difference between a well managed clinic and the casual or careless prescribing of a week’s supply of methadone by the uninterested GP or hospital doctor who just wants to get the patient out of the consulting room – same drug, but a million miles away from the objective and the approach that should be seen in the well organized service. And, at a very literal level, there is now more than methadone. Until recently methadone was the only medication with a product licence for the treatment of the active opiate addict. Like an artist moving from black and white to colour, today’s clinician now has different colours from which to choose. In addition to methadone, a substantial evidence base has been established in the UK around use of lofexidine for opiate detoxification, to which have recently been added buprenorphine for use as a new opiate maintenance pharmacotherapy and LAAM, the long acting pro-drug methadone analogue (both the latter two drugs having been investigated extensively in the US but still currently in their infancy within the UK). Compared with the dark days of yesteryear, the clinician of today is spoilt for choice with regard to selection of specific pharmacotherapy.

Dr Seivewright’s book will guide the reader safely around the different possible choices so as to make optimal use of Community Treatment of Drug Misuse.

JOHN STRANG
Professor and Director
National Addiction Centre
London, UK
Preface and acknowledgements

When I was asked to write a book on drug misuse treatment, I felt that the most important objective was to make it true to life. Treatment of this group can be highly problematic, and to say that things often do not go according to plan is a great understatement. Many doctors and other clinicians are reluctant to be involved, deterred by the behavioural problems, apparent lack of impact of treatments, and other obvious difficulties. The last thing anyone needs is a book which implies that the various treatments can be selected and applied in a simple manner, with ordinary compliance just as in any other condition.

Drug misusers, especially of long standing, tend to have stronger views on their problem than people who have other disorders. They cannot be expected to be neutral about whether they are to receive methadone, whether treatment starts immediately or next month, what dosage of various medications they are to have or, indeed, whether they are likely to go to prison or not. The nature of the condition means that there will be much direct investment in these things, and clinicians are not on the whole well suited to drug misuse if they object to being told how to do their job now and again. Patients may attempt to ‘misuse’ services – and certainly medications – as they do drugs, and any good instruction must acknowledge these kinds of difficulties, and their influence on treatment.

As well as wanting to give the book a sufficiently practical orientation, there were other aspects which appeared important. I was glad that it was to be in a series which concentrates on the social dimension, since social aspects are of huge relevance in drug misuse. In psychiatric practice I have long been aware that aspects such as personality, lifestyle and subculture are typically far bigger determinants of progress than the minutiae of mental state symptoms, and dealing with drug problems especially bears this out. The psychiatry involved in this work is of a very particular type, and a sensitivity to social considerations is vital. I have described the main treatment, methadone, in Chapter 1 as being a medical treatment for social reasons, and in our specialty we are well used to measuring outcomes predominantly in the social arena.

The theme of there being more to treatment than methadone does not
derive from any fundamental reservations about substitution treatment, as any pragmatic clinician should acknowledge that this is essential to have, if only because of general relapse rates. The point is rather that in recent years we have been so dominated by methadone that we have neglected other areas. With ‘low-threshold’ methadone prescribing having been recommended to try to stem the HIV epidemic, huge numbers have ended up on the treatment, in addition to the more established maintenance candidates. As well as wondering how long such treatment is justified, many workers in drug services are concerned that the needs of other users are simply not being met. Young and early-stage heroin users require detoxification treatments, but time must be available for this relatively intensive work. Those who are struggling in their attempts to stay off opiates may only get much attention if methadone becomes indicated. Users of ecstasy, amphetamines, crack cocaine and other drugs barely get a look in. Even with the maintenance candidates, is methadone the best drug? What are the advantages of buprenorphine or LAAM? Why is it said so consistently by some that it would be better to prescribe diamorphine, and that methadone is more toxic, addictive and dangerous? While acknowledging the place of methadone, this book also examines the evidence for a wide range of treatments across the various forms of drug misuse, to help us attempt to offer more comprehensive and equitable services.

There are many commonalities within drug misuse across the world, and this book deliberately adopts an international perspective. There are also many important differences, with some of the most interesting relating to differing treatment policies, and examples of these are explored in several sections. To explain where I am ‘coming from’, both literally and figuratively, and to acknowledge the help of many people along the way, I will briefly recount my involvement in this specialty.

In 1982, my very first trainee job in psychiatry was in Nottingham with Professor Peter Tyrer, who asked me to write this book. I am extremely grateful for the invitation, and even more so for the help and guidance he has given me over all the intervening years. I can only assume he spotted my interest in personality, and therefore personality disorder, as he has involved me in many projects on this subject, and others to do with neurotic disorder, psychiatric services and psycho-pharmacology. As well as being my academic mentor, he instilled in me the principles of community psychiatry, since that first posting and the later research settings were modelled along those lines, and I have professionally grown up with that way of working. My wife Helen, who is a general practi-
tioner and genitourinary physician with an interest in psychiatry, is involved with some of our projects, and Peter has been equally supportive towards her.

As part of the Nottingham rotational training scheme, two years after starting I had a posting at the Nottingham regional addiction unit, with Dr Philip McLean. This was my first experience in drug and alcohol treatment, and I must have enjoyed it, as I have been in it ever since! I did sessional attachments throughout the research fellowship, and as part of all my other postings. This was mainstream clinical experience in a very well established service, and I found that the subject interested me more than any other subspecialty. I therefore have another great debt of gratitude to Dr McLean, who taught me all the basics about the addictions and much more – I think the clinical realism comes from him.

One day in 1988 Dr McLean returned from a visit to inspect the services in Manchester, to say that there was a vacancy as consultant at the Regional Drug Dependence Service there. This was the unit in Prestwich from which Professor John Strang directed the setting up of 19 community drug teams in the surrounding areas, an impressive network which has, through the literature, given us much knowledge about this model of working. With Professor Strang having returned to London, and following a tenure of the post by Dr Chris Fisher, I was appointed to that job and stayed in Manchester for an extremely interesting and formative six years. Patients who required referral to the regional service from the community drug teams were often severely dependent, and it was there that I gained most experience of seeing individuals who were incapable of adjusting to methadone treatment. We had many patients on injectable drugs, and diamorphine and other alternatives were required in some cases. Most of these maintenance patients were not only heavily dependent on opiates but habitually used other drugs, and it was all too apparent that the methadone mixture often cannot serve the needs of such individuals. Not all the patients I saw were of this type as I also did sessions at two of the community drug teams, with a more ‘normal’ kind of caseload. The experience was therefore very broad, and I was pleased to play a part in helping the service become fully active again after a period with no one in post.

In due course in Manchester I was appointed to a Senior Lecturer position in drug dependence, and I am grateful for the guidance in my University work from Professors David Goldberg, Bill Deakin and Francis Creed. I was therefore only half-time in direct clinical work, and the person most responsible for building up the Manchester service (now
called Drugs North West), was my colleague Dr John Merrill, who came one year after me. He has a great commitment to the service and to the field of drug misuse, and with three further consultants now there, Manchester is rightly regarded as one of the leading specialist centres in the UK. I also benefitted during my time there from the expertise of Dr Michael Donmall, an authority on drug misuse epidemiology, whose academic unit was linked with our clinical service, and we have since collaborated on research in cocaine misuse.

My family and I decided that we wished to move back to Nottinghamshire, and to enable this I secured my present job as consultant in Sheffield. This can definitely be called a challenge, as this city of over half a million people has never had an established clinical service for substance misuse treatment. I am grateful to those who had some sessional involvement before I came, particularly Professors Alec Jenner and Philip Seager, and then (in addition to other full-time jobs!) Mr Peter Pratt, Director of Pharmacy and service director, and Dr Andrew MacNeill, Medical Director of the Trust. Peter continues highly effectively as service director, and I have nothing but admiration for the Substance Misuse Team working to establish our presence in the city: Phil Clay, Fran Roman, Kevin Murphy, Giz Sangha, Karen Roach, Sarah Crookes, Michelle Horspool, Kath Barnes and Roger Marshall, and Nik Howes who liaises with us from the Rockingham Drug Project. I am particularly impressed by the work of Sean Meehan, Team Leader, who literally leads by professional example.

I have also been grateful for the help of Dr Charlie McMahon, our previous senior trainee who has since moved to become consultant in addictions in Paisley, Scotland, Dr Roger Smith, highly experienced general practitioner and clinical assistant in Sheffield, and Dr Chris Sudell, who has recently started with us in Nottinghamshire.

I have described in the book some of the work of the two services in which I am employed. Whereas most of the patients whom I see personally in Sheffield are in the substitution treatment clinics, in North Nottinghamshire I have for three years been the only doctor with the service, and so I see a broader range, including many detoxification candidates. This has been particularly instructive, as the services in Nottingham, Manchester and Sheffield have all been, to varying degrees and for different reasons, inclined towards treating more severe patients. My views on treatment have been strongly influenced by the extremely impressive work that is done in the North Nottinghamshire service, and the sections in the book on detoxification and relapse prevention, drug
counselling, and treatment of nonopiate misusers in particular owe much to discussions and joint working with the individual team members. They are: Paul Sales (service coordinator), Donnamarie Donnelly, Majella Kenny, Sarah Peat, Nick Coombs, Cathy Symes, Matt Downing, Jonathan Law and Paul Berry. Although mildly dependent heroin users present to most services, it takes a skilled and very systematic approach to consistently see such users successfully through detoxification, and it is clear to me that this service enables many individuals to become drug free who would, at best, be languishing on methadone if their contact was elsewhere.

There are many other clinical colleagues from the UK and other countries who have taught me much about drug misuse treatment. They are far too numerous to mention, but in offering a general thank you, I will single out Professor John Strang and Drs Michael Farrell, Duncan Raistrick, Philip Fleming, Judy Myles and Colin Brewer, who have all specifically advised me on subjects included here. I was also extremely interested to have several discussions with Dr Alex Wodak and Professor Greg Whelan when I was kindly invited to give a short series of lectures in Australia in 1995, and colleagues in Europe, notably including Dr Henrik Rindom in Copenhagen, and in the USA, have been similarly helpful. Another great opportunity was to coedit and contribute to an international series on addictions for The Lancet, and I am grateful for that to the editors of the journal, particularly Ms Pia Pini, and to my coeditor, Dr Judy Greenwood. A short review of current issues in treatment (Seivewright & Greenwood 1996) provided the basis for some of the ideas in this book. Even having had all these many positive influences, however, there will be deficiencies in the personal view which this book inevitably partly represents, and I bear full responsibility for any of those.

Most directly, I thank the two colleagues without whom the book simply could not have been written: Amy Haddon, my secretary, who typed many drafts and did much associated work while keeping up with the usual National Health Service commitments, and Victor Thompson, research assistant, who undertook the literature searches in an expert manner. Personally, I am grateful in the extreme to my wife, Helen, and our children, Paula and Richard, for their forbearance during my work on the project.

The final note about the book concerns the case histories, which I feel are an important aspect. To preserve anonymity these are composite histories, each containing elements from more than one case, but they
intentionally illustrate the common problems – and successes – which typically emerge in real clinical practice, which straightforward accounts of treatments cannot always convey.

NICHOLAS SEI韦WRIGHT