Book Review

MORE THAN METHADONE

Community Treatment of Drug Misuse: More than Methadone. Nicholas Seivewright. Cambridge University Press, 2000. ISBN 0-521-66562-0

This book is a worthy contribution to the limited literature of chemical dependency at a community level. Dr Seivewright successfully addresses the economical allocation of scarce dependency treatment resources. He also carefully merges the seemingly immiscible concepts of the scientific approach to treatment and the present incarnation of the “British system” of drug control.

The poor standard of dependency treatment in England in recent years has threatened its public acceptance. The National Addiction Centre in London seems not to have adequately addressed these issues which Dr Seivewright and his British colleagues at the coal face deal with daily. This regrettable lack of leadership on opioid treatments lags behind national institutes in Canada, the United States, Australia and elsewhere. Despite a recent masterly contribution in the form of dependency guidelines, there is still no sign of the National Addiction Centre promoting and implementing these clinical directives through the usual medical education channels. They might start with a frank exposé in “Addiction”.

That methadone maintenance in Britain has failed on a practical level would seem to be confirmed by reports of treatment groups with high levels of illicit intercurrent drug use and other poor outcomes (Curran et al., Additional methadone increases craving for heroin: a double blind, placebo controlled study of chronic opiate users receiving methadone substitution treatment. Addiction 1999, 94(5): 665–674) as well as criticism that more people are dying from methadone than from heroin (Newcombe R. Live and let die: is
methadone more likely to kill you than heroin? Druglink, 1996, 11: 9–12). Perhaps these reports are exaggerated or exceptional.

A dearth of medical education about dependency, the lack of supervised medication, inadequate dose levels and an inability to access medication at appropriate times have all combined to sabotage the potential effectiveness of dependency treatment in Britain.

Some have incorrectly excused these inadequacies in the name of “harm reduction” although this philosophy should imply a pragmatic adherence to the scientific basis of treatment in the context of existing society frameworks.

At a time when almost every other European country has implemented methadone treatment for addiction in a scientific and conservative manner, Britain (with some notable Scottish exceptions) retains a haphazard and mixed approach.

Dr Seivewright skilfully skirts this conundrum, knowing that pragmatism requires a compromise between the Rolls Royce and the Volkswagen whether in transport or health care delivery. British doctors (and hopefully, their patients) enjoy a unique privilege by having access to a wide variety of drugs, including heroin in certain cases, for maintenance treatment. Some education and a watchful expectancy may be all that is needed while the natural history of drug use runs its course (see Drug Problems in Britain: A review of 10 years. Edwards and Busch (Eds.), 1981, Academic Press. p. 162). Indeed, that is precisely what we do for tobacco, by far the most dangerous widely used drug. The “British system”, like everything else doctors do, also carries with it an obligation to offer the more specific interventions when these are known to be acceptable and effective. These may include medicated “home” or in-patient detoxification, rapid detoxification, cognitive behavioural therapy, methadone maintenance, antidepressant or other psychotropic medication.

Seivewright sets out the chapters in a manner which is slightly confusing but comprehensive nonetheless. He deals with problems at a practical level using existing services, making logical suggestions regarding new services.

The author states at one point that methadone is the “exception” which can be used as a maintenance prescription, although he concedes elsewhere in the book that LAAM and buprenorphine may also be used in this manner. Nicotine gums and transdermal patches have a
fine research pedigree while maintenance has also been espoused for tranquillisers, stimulants and even heroin. This is only possible where the drug is available in a pure form, and it is paradoxical that for both cannabis and ecstasy, probably among the least harmful and most widely used drugs, neither is commonly available in a pure or standardised form, even for field research.

Seivewright wrestles valiantly with the British contradiction that there is an internationally accepted “best practice” for methadone prescribing which is just not followed in his own country to any great extent. He rightly condemns the severe constraints of some American treatment providers while conceding that this is where much of our research knowledge is based. Quality American research also clearly demonstrates a place for more liberal methadone dosing for long-term, stable patients. This still stops well short of many alternatives including injectables.

The descriptions of tobacco, alcohol and other addictions or predilections are sound and carefully referenced. I think the particularly British term “misuse” should be dropped as it is a value judgement (and hard to pronounce). Why not just “use”?

There are helpful appendices on symptomatic treatments for opioid withdrawal and opioid equivalent doses with a brief glossary and alphabetical index.

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Book Review

BEYOND METHADONE – OR A VIEW FROM THE OTHER SIDE?

Community Treatment of Drug Misuse: More than Methadone. Nicholas Seivewright. Cambridge University Press, 2000. 243 pp. £22.95 (pbk)

Last year a survey, published by The Big Issue in the North Trust, said that “in many respects drug treatment services were failing to help clients and society”. The survey, based on interviews with over 560 Big Issue vendors, received a lot of criticism over its methodology and the way it was presented within the media.

Even if it wasn’t regarded by the field as an excellent piece of work, the survey certainly evoked questions about the length of waiting lists, the escalating costs of methadone treatment and the length of time some drug users are retained in treatment. It may have been “scrappy research” as Fred Yates used to call it, but if we want to be “honest” about what we are there for and contribute to the paucity of existing UK research on drug treatment effectiveness, surely it is the bounden duty of front-line services to use every possible available method and imaginative idea we can think of to find more and better ways to deliver services.

So it was against this backcloth that my interest was aroused by the title of this book “Community Treatment of drug misuse: more than methadone”. The title suggested that here we had a book which would challenge, provoke discussion and take us into and beyond where we are in the debate around current policy, practice and organisation of services for drug misusers.

As you would expect from an author who has acquired considerable knowledge and experience in his field, Nicholas Seivewright has
produced a useful and practical book which covers a difficult topic carefully and well. As Dr John Strang says in his foreword: "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".

I found Dr Seivewright's route into the complexities of drug treatment to be the strongest part of the book. Each chapter gives specific examples of case studies which are combined with clear and invaluable pointers on the range of responses, techniques and measures which are currently employed to meet the needs of drug users.

Nor does he shy away from acknowledging the difficult issues around delays, concerns about access and the debate over the advantages and limitations of methadone as a drug. I particularly like the fact that he challenges evidence based purists nothing that "it is perhaps likely that clinical services will need to identify 'core services', which are strongly-evidenced based, and a range of limited other services for drug problems not associated with such established treatments".

Quibbles? Yes, coming as I do from the voluntary sector perspective, it would have been useful to have seen more exploration of a range of services which tackle the social side of drug use. Page 113 has a very telling letter from a drug user about the feelings of isolation when drug users are no longer part of an identifiable group. Boredom and a vacuum of time is an all too common trigger for relapse. Services which fill that hole and at the same time empower people to take responsibility for their own lives seem to be few and far between, but maybe that's because services in the drug field, unlike the alcohol field, are predominately the realm of statutory agencies!

We are all engaged in different ways in tackling the "sticky issues" which must be addressed if we are to retain public confidence in our services. This book goes a long way in doing something about this. But if it's really going to work I believe we need to adopt the principle that far greater attention needs to be paid to listening to what people are actually saying about their lives and that even "scrappy
research”, which I am sure Dr Seivewright would agree, can play an important role in achieving changes and diversity in our approach to treatment.

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