Burgered: quality of life and addiction treatment

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The author is grateful for the comments and encouragement of Peter McDermott, Gillian Tober, Jon Derricott, Maggie Rogan, and John Witton.

Would you rather be feeling and functioning well and having the odd glass of wine – or snort of cocaine – or abstinent with a poor social life and feeling bad? For most alcohol or drug treatment outcome studies, it's no contest. Rarely do these forefront what matters most to the patient – their quality of life as they define it. Such measures are especially rare in relation to illegal drug users (Graham et al, 1999). Instead the focus is on the outcomes that matter most to the broader society – eliminating illegal drug use, reducing crime, and curbing the burden placed on medical and law enforcement systems. This would not be an issue if in practice objectives coincided and national and local target-setters, services, and service users were pushing in the same direction. We know little about this, but the little we do know indicates that often this is not the case. Realising this casts an entirely new light on 'poor' outcomes as such as 'relapse' after detoxification, 'drop out', and the 'inability' of methadone services to prevent their patients continuing to use heroin. Seen as signs of failure by the services and their funders, from the client's point of view these outcomes may be generated by a successful co-option of the service in the pursuit of their own agenda. Using the client's assessments of their quality of life as a yardstick would often give a very different impression of well a client has done and how well a service is performing. For national policymaking, the implications of this simple and unsurprising observation are profound.

Part 1 of this article establishes the disjunction between what the client values and what treatment aims for and is assessed by, a fairly straightforward matter of record. Part 2 deals with the more controversial issue of what one makes of this disjunction in terms of addiction policy and practice. Inevitably this brings into play understandings and values related to the nature of addiction, the relationship between services and clients, and ultimately between citizens and the state. Interpretations will vary. Some might, for example, say addicts are suffering from a brain disease of which the disjunction between what they need and what they say they want is a symptom, a variety of denial. That this disease makes their judgements of what's good for them unreliable and subservient to those of the clinical experts on their condition. Others that by breaking the law, aggravating the community and demonstrating moral weakness, addicts forfeit the right to self-determination and must make the best of what society chooses to make available to them in the interests of the majority. Part 2 offers a different interpretation, inspired by the famous burger chain McDonald's, itself the subject of much controversy.

PART 1. QUALITY OF LIFE POORLY RELATED TO CONVENTIONAL OUTCOME MEASURES

Evidence of a disjunction between the patient's own assessment of their physical, emotional and social well-being and conventional outcome measures has emerged from the few studies which have extended quality-of-life measurement (common with other patient groups) to drug and alcohol users. The studies involved very different patients treated in very different settings, suggesting that this disjunction may be quite generalised. Satisfaction with treatment, another measure taken from the client's point of view, is also inconsistently related to substance use outcomes but may (there is very little evidence) be more closely related to quality of life.

In one US study, whether a client was using substances more or less often during a three-month treatment trial bore no relation to improvements in their quality of life over the same period (Morgan et al, 2003). At the end of treatment, on different sub-scales

between a third and a half of the clients who had sustained abstinence during treatment nevertheless had a poor quality of life, while around half who had lapsed into substance use had a good quality of life.

Though it did not use formal quality of life measures, a disjunction between quality of life and substance use also emerged from a study of 628 previously untreated problem drinkers who contacted information/referral services or detoxification units and were followed up one, three and eight years later (Moos et al, 2003). Across the eight years, treatment duration was consistently linked with better drinking outcomes, but there was generally no link with improved social functioning or relief from depression.

In Australia 44 benzodiazepine users seeking in-patient withdrawal at two substance use treatment clinics were randomised to fixed and symptom-triggered taper methods (McGregor et al, 2003). In both groups there was a substantial and significant reduction in benzodiazepine use between intake and the follow up four weeks later, but a health-related quality of life scale recorded no significant improvements on five out of seven sub-scales reflecting general health, vitality, social and emotional functioning and mental health.

Primary care patients in Pittsburgh were screened for actual or potential alcohol problems and randomised to two different forms of brief intervention or standard care, none of which seemed preferable to the others in terms of outcomes (Kraemer et al, 2002). A year later there were only modest relationships between drinking reductions and improvements in quality of life. Depending on the cut-off points used (20%, 30% or 40% drinking reductions) these relationships were either not statistically significant or only marginally so.

A demonstration project providing integrated mental health and substance abuse treatment to patients with (or with histories of) both types of problem recorded significant improvements on a quality of life measure and other measures related to quality of life and functioning, at the same time as there were no changes in substance use as measured by the Addiction Severity Index (Judd, 2003). Unfortunately the study did not report drug use measures directly, leaving the possibility that the ASI failed to pick up on significant changes in levels and types of drug use.

A study in eleven methadone maintenance programmes in eight European nations also recorded a disjunction between quality of life and reductions in illicit drug use (Ghodse et al, 2003), but one less stark than in the studies cited above of alcohol or mixed alcohol/drug patients. Compared to new patients, those who had been in treatment for at least two months and up to six months had significantly lower frequencies of illicit drug use, of illicit opiate use in particular, and of injecting, but not until patients had been in treatment for at least six months did improvements in quality of life became statistically significant.

In Canada a research team has developed a tailor-made scale for measuring drug injectors' quality of life (Brogly, 2003). Importantly, it allowed the user themself to determine which aspects of their life were important to them and how important they were relative to other aspects. It was tested on 61 Montreal mainly unemployed, single cocaine injectors, 85% of whom were reassessed within four weeks. For them, drug use as such was way down the list of issues which they saw as important to their quality of life. Most frequently prioritised were health, housing and money. Except at the extremes, what they saw as important bore only a weak relationship to the frequency of cocaine use.

Different relationship with alcohol versus drug use?

At least two treatment studies have been able to directly address the issue of whether quality of life is more closely related to illegal drug use or to alcohol use or problems. Both found the relationship with drug use was closer. The first interviewed a representative sample of patients undergoing publicly funded substance abuse treatment in Massachusetts (Smith et al, 2003). Quality of life was unrelated to the severity of alcohol problems as measured by the Addiction Severity Index, but there was a modest relationship with the severity of drug problems in the expected direction: quality of life was lower the more severe were the patient's problems.

Similarly, at two Canadian addiction treatment centres, psychological and social functioning and life satisfaction 12 months after treatment were generally unrelated to the extent of drinking among either alcohol or drug clients (Graham et al, 1999). However, drug use outcomes among drug clients were strongly related to emotional well-being and life satisfaction. In general, studies find that not until it reaches the point of very heavy or uncontrolled drinking is alcohol use after treatment related to psychosocial functioning.

If there is a different relationship between quality of life and drug versus alcohol use outcomes, it may stem from the more socially integrated position of alcohol in the societies where the studies have been done. In these societies it is easier to sustain a normal and fulfilling life while drinking than it is to do so while taking, say, heroin or cocaine, and because it is a far more normal activity, having a drink is less likely to be a marker of life problems than relapse to heroin or cocaine use. The latter mechanism seems apparent in the Canadian study's finding that negative emotions strongly predicted a more rapid return to drug use, but not to drinking.

Which treatment is better?

Other studies confirm what is implicit in the work already cited – that using the patient's own account of their quality of life can overturn conventional assessments of which treatment is best. A US study of severely dependent drinkers being treated for medical illnesses randomised them to referral for alcohol treatment as usual (few went) or to receive alcoholism treatment alongside their medical care (Willenbring et al, 1999). Two years later integrated alcohol treatment had led to significantly increased abstinence rates and cut alcohol consumption, but there were no significant differences in how well the two approaches had improved the patients' assessments of their quality of life.

The same message comes from another US study which alternately assigned mentally ill substance misuse clients to group therapy either along 12-step lines, or using a cognitive approach focused less on abstinence than on correcting irrational beliefs thought to underlie dependence (Brooks et al, 2003). As expected, the 12-step intervention led to less drinking (the main problem for nearly half the samples) and less cannabis use, but it was also associated with a *worsening* in employment status and on several dimensions reflecting health-related quality of life. Clients in the cognitive groups did less well in reducing substance use but did improve their health-related quality of life and employment status. The authors argue that the new ways of thinking encouraged by the cognitive intervention helped participants take charge of their lives and problems in general. We can further speculate that now too they were able to 'enjoy' and control their drug use, rather than it seeming to control them. Without quality of life measures, the

greater reduction in drinking and drug use in the 12-step programme would have made this seem indisputably the better treatment.
An Austrian study of opiate addiction treatment compared buprenorphine maintenance to methadone (Giacomuzzi et al, 2003). After 24 weeks, urine tests showed that the buprenorphine patients were far less likely to be using illegal opiates or cocaine (traditional measures of success), but also that there were no significant differences in quality of life, which for both groups had improved since they entered treatment. The main author suspects that some patients were trying to increase their quality of life by supplementing their prescription with other drugs (Giacomuzzi, 2003).

'Illegitimate' objectives

The opioid maintenance studies cited above hint at something tackled directly in other work – that some heroin addicts enter methadone maintenance with goals in mind which do not include and may even be incompatible with abandoning a heroin-based lifestyle. If they reach those goals, they might (if asked) express satisfaction with the treatment and report an acceptable quality of life, even when conventional measures such as abstinence from illicit heroin and retention in treatment register a 'failure'.
At a US clinic, patients who continued to supplement their methadone with heroin were similar to those who did not on nearly every objective measure of problem severity at intake, and many were on relatively high doses of methadone. Informal interviews suggested that commonly they had used methadone to cut down on heroin but that they simply did not want to stop using the drug (Belding et al, 1998). Similarly, in a US trial of methadone maintenance versus reduction, continued frequent heroin use despite high doses of methadone seemed to be accounted for by the fact that only half the clients entered treatment with abstinence as their goal (Bell, 1998).
In other studies, addicts reported various motivations for entering methadone treatment other than giving up heroin, such as restraining their consumption, taking a short respite from the hassles of their lifestyle (Bammer, 2000; Bell, 1998), or having a taste of what life without heroin might be like (Koester et al, 1999). Such patients will tend to dip in and out of treatment, the kiss of death for methadone maintenance services for whom retention is the key performance indicator. To the service they will seem to have been failures and to its funders will make the service look poor, yet the patient may have got precisely what they wanted. Other patients avoid high methadone doses in order to continue to enjoy heroin (Koester et al, 1999). Appreciating this, Dutch methadone services deliberately prescribe relatively low doses (Central Committee on the Treatment of Heroin Addicts, 2002). By accepted international standards geared to eliminating heroin use, they may be criticised for under-dosing, but are in fact simply responding to what the customer wants.
Interestingly, the tension between client and service objectives has been seen as generating the most influential new therapeutic approach in addictions (Woody, 2003). "Ambivalence toward stopping use altogether would manifest in patients who desired help but avoided entering traditional addiction treatment due to its strict abstinence requirements. Clinicians theorized that more of these patients might enter and remain in therapy, and eventually achieve abstinence, if the therapist focused on resolving the ambivalence rather than demanding immediate abstinence. These observations led to studies of [motivational interviewing] and [motivational enhancement therapy]." In other

words, rather than seeing this disjunction as a sign that treatment needed to be realigned with the patient's priorities, researchers and clinicians set about developing technologies to realign the patient with their own priorities.

I'm satisfied even if you're not

It seems likely that satisfaction with treatment a more commonly taken measure and quality of life both at least partly reflect the client's assessment of the degree to which they got what they wanted out of the treatment. If there is a mismatch between what some patients want and conventional outcome measures, then we can expect this to be seen not just in respect quality of life, but also between these outcomes and the patient's satisfaction level.

As a leading American researcher has commented, typically this is exactly what is found (McLellan, 2003), particularly if the outcome is abstinence. Project MATCH might seem an exception but on closer inspection at least partly confirms previous work. Satisfaction with MATCH's three alcohol treatments and in-treatment drinking did co-vary, but the relationship was complex (Donovan et al, 2002). Findings from the 'outpatient' arm of the trial were uncomplicated by prior intensive treatment. In terms of clinical rather than statistical significance, among these clients, satisfaction was more strongly related to the number of drinks per drinking day (varying from a hefty 10+ UK units a day for the least satisfied third of clients to a modest 3–4 units for the most satisfied) than to the number of days of abstinence (varying little, from about 90% to 70%). There was also a very strong relationship with 'clinical status' at the end of treatment. On this more rounded measure, clients could register good outcomes even if they continued to drink regularly, as long as their intake was moderate and problem free. Nearly 60% of the highly satisfied patients had a good outcome on this measure compared to a quarter of the low satisfaction patients. In other words, the closer the measure was to something like quality of life, and the further it was from abstinence, the closer it was related to satisfaction.

In a US study whose subjects were mainly problem drinkers, satisfaction with treatment was unrelated to participation in treatment or to the number of days patients remained abstinent in the six-month follow-up period (McLellan et al, 1998). Similar findings emerged from another US study, this time mainly of people with problems related to illegal drugs. The clients' ratings of benefit from treatment – a proxy for satisfaction – were only marginally related to the number or proportion of clean urine tests or to retention in treatment (Gottheil et al, 2002; Thornton et al, 2003). A British study at a short-term residential service for alcohol and drug users also found satisfaction with treatment unrelated to retention (Georgakis, 1997).

In contrast to substance use outcomes, one of the few (if not the only) studies to test this relationship found that satisfaction with treatment was very strongly related to quality of life (Holcomb et al, 1997). The patients were psychiatric and substance misuse inpatients whose quality of life, emotional well-being and functioning (disruptive behaviour and living skills) were measured before and after treatment. Improvements were strongly related to how satisfied they were at discharge with the treatment facility's staff, programme and environment. Unfortunately the two groups of patients were conflated in the analysis.

PART 2. THE HAMBURGER FALLACY

We'll return to quality of life via what may seem a detour (but believe me, the road circles back) through the intriguingly titled, "What do hamburgers and drug care have in common: some unorthodox remarks on the McDonaldization and rationality of drug care." In this article, Uwe Kemmesies (2002) described trends (and counter-trends) in a national drug treatment system which parallel what McDonald's exemplifies in the restaurant business. The nation was Germany, but a British reader might easily think they were reading about contemporary Britain. "The ideal-typical model of drug care was visualized as an interlocking system or therapy chain based on a division of labour (counseling centers, therapy facilities, and aftercare facilities). It was thought that this could ensure the efficient achievement of abstinence. Drug treatment providers thought of this system as a paragon of efficiency because the people it was designed to treat did not have any choices to make. The long-term objective and the stages involved in getting there were clearly defined and institutionalized."

Readers familiar with these documents will find it hard to not to bring to mind the English National Treatment Agency's *Models of Care* (National Treatment Agency, 2002) with its "integrated care pathways", "designed to standardise elements of care ... and thus improve treatment efficiency, effectiveness and value for money", and the similar vision in guidance from the Scottish Executive, for whom the same pathways crystallise "current best evidence ... to outline the optimal course of care for all clients who have a specific condition or who are undergoing a specific procedure ... the optimal sequence and timing of interventions by physicians, nurses, and other professionals" (Effective Interventions Unit, 2003).

Models of Care's and the NTA's strapline – "Promoting quality, efficiency and effectiveness in drug misuse treatment services" – encapsulates what Kemmesies sees as the defining features of McDonaldization: efficiency – choice is confined to centrally defined, 'optimum' means to an end; predictability of inputs and control over outputs ensured by quality control systems; control itself, achieved through "manuals prescribing accepted procedures and techniques" and by the circumscribing of choice to a predetermined menu. Underlying it all is an emphasis on the quantity of treatment contacts rather than their quality, reminiscent of the performance indicators used to assess the progress of the national drug strategy within which *Models of Care* is positioned as a technical manual.

These striking coincidences of terminology may be nothing more than that only a detailed examination of policy and practice can establish what is truly meant by "quality", whose quality it is, and whether "efficiency" is about the unarguable maximisation of outputs for inputs or represents a counterproductive standardisation of both and a denial of individuality and creativity. No one within the structures concerned need personally endorse the latter position and may passionately and genuinely believe in individualisation and creativity and in improving the welfare of addicts, and to a degree this may also be the effect of their efforts. But like the current author, like drug counsellors, and like addicts themselves, they work within structures and spoken or unspoken assumptions which are hard to see, let alone challenge, and which may generate countervailing undercurrents.

Irrationality of standardisation

Other readers will be able to find parallels to the McDonaldization process in their own

written or unwritten national strategies, in so far as these set pre-ordained means to pre-ordained objectives, which might bear little relation to what is important for the individual. Kemmesies argues that at the heart of this seeming rationality is an inherent irrationality – that getting in to and out of addiction are highly individualised processes, and that in social care generally there can be no standardised outputs. The rest of this article picks up this argument and runs with it in directions of which Kemmesies may or may not approve.

The first sprint is to a simple deduction. If it is the case that there is no such thing as 'addiction' as a unitary medical or psychological condition, or even a set of such conditions ('addictions'), then it also makes no sense to construct unitary, standardised responses. This is like developing standard medical responses to the behaviour we recognise as limping. Any number of conditions and concatenations of circumstances can lead to this behaviour including being kicked by the doctor, hobbled by prison chains, a cancer, or a poorly fitting shoe, it may or may not bother the limper in any number of different ways for shorter or longer periods, and what they want done about it, if anything, will similarly vary. We may need a doctor to fix it but we may as easily need a good shoe fitter or a lawyer. The unitary nature of the behaviour does not mean there is a similarly unitary cause or a standard set of responses. Developing such responses to the behaviour will enhance 'efficiency' and help to ensure consistency and control over inputs, but they will often miss their mark. Given this perspective it comes as no surprise that the most predictable outcomes (and even these can be hit and miss) are produced by 'treatments' such as methadone maintenance which simply reproduce in modified form the behaviour the common feature rather than tackling addiction, the presumed underlying condition. A deep irrationality is hidden by the surface veneer of efficiency. The result can be that a system which seems to enshrine efficiency fails to deliver well even on its own objectives. Carrot-and-sticking services to aim at centrally determined crime and substance use reduction targets is another way in which a seemingly rational system can work against itself, for aiming directly at those targets may not be the best way to hit them. It seems likely that staff who respond to the client's needs and ambitions without these hidden agendas and ulterior motives will come across as more genuine, caring, responsive, empathic and respectful, the essence of effective therapy. Precisely because they are not directly aiming at them, as a side-effect they will achieve national objectives. Again, there is an analogy in the restaurant business. The owner's ultimate objective may be to make money, but the best way of doing this is to hire chefs who care nothing about money and everything about food and satisfying the customer.

In England and Wales we may be seeing some of this in the appalling failure of Drug Treatment and Testing Orders. Nearly 7 in 10 of these which have ended, have ended in failure – reconviction or more likely the return of the offender to court and probably to prison for not complying with centrally prescribed requirements (Home Office, 2003). The result is that within two years of starting their orders, 80% of offenders at pilot schemes had been reconvicted (Hough et al, 2003). Where, as in one of the English pilots, national requirements were compounded by an inflexible standardisation of means and ends focused on abstinence (Turnbull et al, 2000), the failure rate was even higher. In Scotland (Eley et al, 2002) where the leeway to customise the programme and adapt to the individual is considerably greater, and at English schemes more prepared to treat the offender as an individual, completion rates can be dramatically improved.

In Germany there were counter-trends and so too are there in Britain, primarily in the form of harm reduction services which open up the range of acceptable objectives from which drug users can (if allowed by law and service provision) choose, and an emphasis on user/carer consultation and partnership based on seeing the addict as a user of the national health service with the same rights to influence their care as any other patient. But all this occurs within a system which sets pre-ordained objectives and outlaws others, limits within which the customers and their therapists must constrain their choices and ambitions, or at least pretend to do so. In *Models of Care* the term 'client-centred' uncomfortably rubs shoulders with pre-set abstinence and treatment compliance targets and standardised outcome measures such as the Addiction Severity Index, and in the end it is delivering on these which will decide whether a service lives or dies and a drug action team is congratulated or castigated.

Baby exits with the water?

At McDonald's the 'chef' never gives in to inspiration by suggesting that you might like this or that added to your burger, or even if you'd like this or that taken out, and those who ask quickly learn that this is not how it is done. It avoids disasters but also those sparks of creativity which could light up the encounter. However, a landscape populated by McDonald's with not even a transport cafe to lower the tone would be preferable to an eating-out industry which served dangerously undercooked food, laced roast dinners with custard, and blamed its customers if they walked out. This is precisely the justification for their strong line advanced by the National Treatment Agency, which openly criticises the field it was set up to reform.

There is a real chance that at the end of the processes they have set in train, we will have a drug treatment 'system' at least worthy of the name and better in whatever way we measure it than the mish-mash that went before, based too often on the individual prejudices of powerful practitioners or managers. Still, in their bones experienced and respected workers feel something is wrong and mutter or openly rebel (Davies, N., 2003) at the centrally driven requirements they feel distancing them from their clients. Drug users who have suffered at the hands of the incompetent, ignorant, self-important or misguided among the workforce back the NTA's strategy, but at the same time can feel the baby being thrown out with the bath water, complaining about the de-individualisation of treatment inherent in prescriptive 'guidelines' and reminding us of the days when 'mavericks' bucked the consensus to deliver what their clients wanted (McDermott, 2003a). At the same time as it irons out unacceptable deviations, *Models of Care* can also be used to "stamp out innovation and services that are seeking to provide ...'quality of life' interventions" (McDermott, 2003b). Indeed, these may themselves come to be seen as unacceptable deviations.

Rational within a limited perspective

What seems rational or true within a limited perspective can seem irrational or untrue when vision is broadened. Commonly this is how science progresses, coming to appreciate that what today seems an unquestionable and universal truth looks this way only because the universe we are seeing it within is so narrow. In turn this shift of understanding alters how we see even the original narrow domain, transforming 'universal truths' into ephemeral special cases which can change when the environment

changes. By definition, consensus documents crystallise the narrow overlap area where agreement or at least toleration is possible. By throwing up unexpected findings, research can force a shift of perspective but research can also derive from and work within the consensus, investigating and measuring only the things which seem important within that compass and treating intrusions from elsewhere as 'noise'. When inconsistencies nevertheless arise, they may be ignored as meaningless puzzles or re-interpreted to safeguard the initial perspective, as in the resort to 'denial' to explain why people who supposedly need the help on offer nevertheless refuse it. The result could be an inbred, self-perpetuating narrowness of perspective within which certain approaches are promoted as the only ones with an evidence base, not because other possibilities have been tried and failed, but because they have not been tried, not been tested, or perhaps not even envisaged.

Like the US NIDA treatment improvement protocols (TIPS), *Models of Care* is not new thinking but a consolidation of old thinking contained in existing guidance, supplemented further by the same professional consensus which helped produced that guidance, and by research, much of which is generated within the same paradigm. In promoting *Models of Care* as the way things should be done, the agency behind it appeals to its foundation in "professional consensus ... current evidence, guidance, quality standards and good practice." As a government product, it is careful to stay within existing guidance and legislation. NTORS, the major piece of home-grown evidence available to challenge accepted practice, itself derives from the heart of that consensus, the National Addiction Centre with its close ties to the addiction services of the Maudsley and Bethlem hospitals. Commissioned by an enquiry set up by a hostile health minister, ironically the research was put in the hands of researchers and clinicians who can be expected to have had (indeed, *should* have had) a deep investment in the services the minister so bluntly questioned. They made choices which to them must have seemed perfectly defensible but which to external observers were puzzling. These included the aggregation of expensive hospital inpatient units under the wing of residential rehabilitation services in a way which prevented their performance being separately scrutinised, and the unusual method chosen for determining the top and bottom of the fraction which produced the headline-grabbing '£3 return for £1 invested' calculation (Ashton, 1999a). The study left out services beyond the accepted remit of drug 'treatment' or 'rehabilitation' such as drop-in advice centres and needle exchanges. Services which did not focus on drugs at all but on housing, education and employment too were omitted, as were the 'natural' processes in non-treatment populations which might promote recovery and might themselves be promoted by broader social policy such as community cohesion initiatives. In other words, the study started from a narrow vision of what an intervention to promote and sustain recovery from addiction might look like. The researchers themselves had a far broader perspective but the services they chose or were mandated to study implicitly treated (in both senses of the word) addiction as a psychopharmacological disorder located in the addict, leaving services outside that sphere without much of an evidence base to stand on.

Most of the rest of the evidence base derives from the USA where the idea of specific treatments for specific, diagnosable medical or psychological pathologies is generated by the need to justify funding within private and managed health care systems. Such claims to technical fixes for a bona fide disease also maintain the position of clinical experts in

these technologies (Littlejohn, 2003). The US National Institute on Drug Abuse tells its teenage web visitors that "drug addiction is a complex brain disease" (National Institute on Drug Abuse, 2003). When it comes to answering their queries about how quickly you might become addicted, the only influences itemised are "your genes ... and the biology of your body." Its new director, Nora Volkow, "a recognized expert on the brain's dopamine system", optimistically reminds us that "Every day, diseases that were previously little understood, such as obesity, diabetes, mental illnesses, and now addiction, are being conquered by science ... NIDA will take full advantage of the explosion of knowledge that is occurring in the technology and biological research arena, from the Human Genome Project to the use of neuroimaging and 3-dimensional brain mapping models". We might dismiss this pie-in-the-sky poppycock, except that she heads the agency which claims to support "85 percent of the world's research on the health aspects of drug abuse". Dominating its work is the concept of addiction as a neurochemical disease created by regular consumption of certain (mainly illegal) chemicals and also amenable to chemical (this time legal) solutions if only we could find them, and if only the addicts did not so often abuse or fail to comply with the chemical fixes we come up with.

But even within this neurochemical world, the protective nature of satisfying social relationships may be seen. Monkeys isolated in cages self administer cocaine sometimes to addictive levels, but when transferred to group cages holding four monkeys each, those who became socially dominant administered relatively little (Martin, 2003). Apparently their social status did a good enough job at raising their brain dopamine levels and cocaine was not needed. The subordinate monkeys carried on fixing. There seems a clear parallel with the protective nature of social 'capital' (the key element of 'recovery capital', of which more below) in human beings and the converse vulnerability of the socially stigmatised and excluded.

What counts as an intervention?

Reliance on an inbred combination of guidance, professional opinion and research, results in a blinkered vision of what a helpful intervention is, what makes it work or not, and what 'working' might mean, bolstering approaches which position the problem to be treated within the head of the addict and which are based on conventional presumptions of what constitutes a good outcome. Systematising and documenting responses based on this paradigm at least helps those working within it to consistently and efficiently miss (what for the client may be) the mark, or at best to hit it by accident or through those neglected influences such as the common humanity of the therapist who 'delivers' the intervention or of the nurse who administers the prescription. Such perspectives become self-perpetuating in another way, because individuals and services are unwilling to risk being pinned down as on the wrong side of a consensus which is no longer vague and undocumented, a risk of which some in Britain are acutely aware (Littlejohn, 2003). Christopher Littlejohn, a nurse working with problem alcohol users in Scotland, was referring to that country's new alcohol treatment guidelines. With questionable faith in the adequacy of the evidence, these commend just four types of relapse prevention therapy and say "other psychosocial treatments are not recommended as their clinical effectiveness is unproven." Moreover, the favoured interventions "should be carried out in accordance with standardised protocols" and be made "as similar as possible to that

which has been shown effective in clinical trials" (Health Technology Board for Scotland, 2002; Slattery et al, 2003).

Services which work within such frameworks need do little more to justify their work even if it has no reliable research backing, but those which deviate can be expect to be called to account. Similarly in *Models of Care*, "Departures from ICPs are sometimes required ... but they should be justifiable" (National Treatment Agency, 2002). The integrated care pathways being referred are to be developed locally drawing on national models. They are sophisticated administrative tools to streamline decision-making, improve efficiency and create consistency, but they depend critically on the initial assessment which determines who needs to traverse which pathway. At this point the edifice can be seen to have been erected on the flimsiest of foundations. For example, when describing which clients might be eligible for residential care the guidelines are little more than an extended statement that it should be clients who need and want this degree of care, a circular route which takes us nowhere. When later it gets more specific, *Models of Care* reproduces (without attribution) the criteria developed by the American Society of Addiction Medicine. These have been tested and found inadequate (Klein *et al*, 2002) and in one study quite useless (McKay et al, 1997). There are more promising models, (Melnick et al, 2001) but beyond the blindingly obvious (such as that methadone maintenance patients should be regular opiate users), assessment for different treatments is largely a scientific black hole. So *Models of Care* and its Scottish equivalents risk sending drug users down efficient pathways which may be leading in the wrong, or at least not the best, direction for that client. Despite this fundamental flaw, the practitioner who departs from these models may well feel they are sticking their neck out. 'It was what the patient and I thought would work best for them' will seem a lame counter.

Also on shaky ground may be services such as the voluntary day care service which does not require its clients to attended for a set number of hours or to undergo a set programme. Beyond basic skills (among which it numbers teamwork in the shape of five-a-side football), it takes its lead from what interests the client and what they can manage at this stage of their recovery. There is no drug counselling or group therapy and talk about drugs or alcohol is discouraged. The aim is to approach the former addict on another level, as someone interested not just in drugs but in a home, a career, and in developing themselves and their skills. It would fall foul of the requirements for structured day care, one of the supported modalities in *Models of Care*, but a limited evaluation records positive results (Spurling et al, 2002). From this perspective we can see educational services, housing, training and retraining programmes, and community regeneration, all as potentially powerful forces for addiction treatment and rehabilitation even though this not at all what they are about. This is one of the lessons of research which steps outside treatment to see how people recover without formal help, of which more below.

Even within conventional drug treatment and rehabilitation, we mistakenly focus on the treatment model as the active ingredient and develop workforce strategies and standards to skill staff in these treatment technologies. Yet time and again, in both alcohol and drug treatment, what emerges as important is not the manual or how well it is followed, but the personal and interpersonal qualities of the man/woman doing the therapy. The same human qualities which make life better outside treatment do most to make it better within – empathy, understanding, the ability to communicate, genuine caring, respect for the

individual, responsiveness (eg, see: Cartwright et al, 1996; Blaney et al, 1999; Joe et al, 1999; Fiorentine et al 1999a, 1999b; Bell et al, 1997; Saarnio, 2002; Valle, 1981). These qualities may be capable of being quashed by insensitive management and hampered by lack of time and resources and perhaps too by over-prescriptive guidance but there must be a question mark over how far they can be taught. The reason why what can be taught – formal treatment models – generally produce equivalent outcomes and cannot reliably be matched to different clients, is simply because the model matters relatively little. It is what is commonly studied, not because it is important, but because it is what researchers can control by giving the therapist a manual, training them, and making sure they follow it. The underlying stance of this type of research is, 'Only that which I can control is important'. Everything else is 'noise' to be eliminated from the study through mechanisms such as random allocation of therapists and clients. Luckily, this 'noise in the system' is so powerful compared to the generally minor impact of treatment models that it is difficult to subdue. Irrationally, as Kemmesies might have it, practice and research collude to focus on the unimportant. In both 'quality' is misconceived and replaced by controllable variables amenable to quantitative assessment.

Inside and outside the box

The apotheosis of the vision of treatment as a technical fix to a medical or psychological disorder was Project MATCH, which sought to match particular types of alcohol dependent patients to distinct psychosocial treatments. In this respect it was a spectacular and, for its instigators, a totally unexpected failure. The three therapies, engineered and tightly controlled to maintain their distinctiveness, did not lead to correspondingly distinct processes of change in the clients nor to distinctive outcomes for different types of clients. The shock drove MATCH's respected researchers (one of whom was William Miller, of motivational interviewing fame) very far from the project's starting point (Babor et al,. 2002; Ashton, 1999b). They came to argue that treatment merely gives people 'permission to recover' and provides some of the social and other resources which may be lacking in the patient's life. The more important active ingredients are not treatment technologies at all, but features which cut across them such as "empathy, an effective working alliance between the therapist and the client, a desire to get better, the alcoholic's inner resources to overcome alcohol dependence, a supportive social network, and the provision of a culturally appropriate solution to a socially defined problem." The last phrase is critical and profound in its implication that society both constructs the 'illness' of alcoholism and then constructs accepted routes out, which in the West we call treatment. Even more so for addiction to illegal drugs, in a sense social exclusion *is* the 'illness', and just as we can help create it, we can also help reverse it if our perspectives are not themselves chronic and relapsing and if the damage is not too severe for the resources we are prepared to apply.

Starting from the heights of US therapeutic technologies, MATCH's researchers ended up appreciating that in essence these were no different from what a good faith healer or witch doctor might provide in other societies which demonise certain behaviours or people but then also provide socially accepted routes to redemption, which work precisely because the 'disease' is itself a social construction. For them their unanticipated findings called to mind the works of therapists who saw "trust, belief, and hope" and "empathy, genuineness, and warmth" as responsible for enabling change. One far-

reaching implication is that “access to treatment may be as important as the type of treatment ... the real value of having an array of treatments available is to promote healthy competition for the wide variety of people who would benefit from any treatment, but who would be more attracted to one because of reputation, convenience, or personal preference” (Babor et al, 2002). Such thinking is so far outside the box that there is no inkling of it official guidance. But if the MATCH team’s suspicions are right, then we are also right to be concerned about the premature narrowing of options to the few which have gathered an evidence base around them or can attract consensual support (Littlejohn, 2003).

Addiction is socially generated

Also well outside the box are the lessons of research not of treatment at all, but of how people recover from addiction without treatment. Deep within the consensus on which *Models of Care* elaborates its models is the mantra of addiction as a ‘chronic relapsing’ condition. Like the idea that there can be technical fixes, this construction survives only because of the narrowness of the vision within which it seems to make sense, a vision seen through the narrow slit of research confined largely to treatment populations. The individual addict as they present to the doctor or therapist is physically and mentally abstracted from their social nexus past and present. They enter a domain which encourages them to be seen and to see themselves as an isolated entity, contained within which is the stubbornly persistent condition called addiction. There is an alternative vision of the individual as the focus of a spider web of social relationships, some personal and direct, some distant and mediated. At the centre where they cross there is a solidification of the image which at a glance is all that can be seen, the individual. What makes them individual is that they have their own characteristic ways of integrating the strands, resulting from the incorporation of past relationships, but until death intervenes their construction as a human being remains a dynamic social process. Within this broader perspective, what is chronic is not a condition in the addict’s head, but the way they relate to the world around them and how it relates to them, a two-way process as much in our heads and hearts as in theirs. Typically addicts seen in treatment services lack the physical, economic, and psychological resources and most of all the social links which other people draw on to lever themselves out of a bad patch without resorting to formal help, conveniently collected under the umbrella of ‘recovery capital’ (Cloud, 2001; Klingemann, 2001). The same processes may have made them vulnerable to addiction in the first place. These processes are not due just to them but to how society doles out its resources and maintains or severs contact with its more atypical members. In these ways the supposedly universal truths of addiction are created by ourselves and can be changed, not only by changing the addict, but changing how we relate to them, which in turn changes them in a seamless interaction. We create our own realities, in this case the condition we dub addiction and attribute to the addict. The latest version of the internationally accepted diagnostic criteria for substance abuse and dependence (included in DSM-IV) incorporates "impaired functioning within the context of one’s environment" among its symptoms of abuse and dependence (Ridenour et al, 2003). How that environment reacts to you and the economic and other resources you have to prevent impairment, or to prevent it becoming a problem, partly determine whether you will fit the diagnostic bill. The same cocaine use pattern which sends a poor man or woman to

prison and affects their work performance and their ability to care for their family, in a rich user may not have those consequences because they have no need to work, can hire helpers, and can ensure privacy and buy discretion. The poor man will be DSM-IV addicted, the rich man may escape this diagnostic stigma.

Similarly, the 'natural history' of progression from use to abuse and dependence is not natural at all, but a function of the social environment which leads opiate and cocaine abusers to hide their abuse, creating a relatively rapid transition to addiction once impaired functioning becomes apparent to those around them. This rapidity relative to more socially acceptable substances like alcohol and even cannabis may also be a function of the addict identity forced on opiate and cocaine users by a society which makes use of these drugs central to who and what you are, leading the user to do the same.

So too the apparent intractability of addiction is in part a reflection of our inability or unwillingness to do enough to create or recreate the resources needed for sustainable recovery. Treatment is not cheap, but decent housing, education, employment and supportive communities and relationships are far harder to engineer, and ensuring access to these challenges the foundations of a society built on inequality, which must have its losers as well as its winners. By generally failing to pay sufficient attention to these factors, treatment programmes ensure that their customers return again and again (South et al, 2001). But in truth, when labour of the kind they may be fit for is not in demand and after the erosion of public and affordable housing, reintegration is no easy matter.

Worse, though those who later become addicts may start with few resources, what they have may be taken away by criminalisation and social stigma, and by services which encourage the adoption of an addict identity. Clinging to the non-drug related social ties (family, non-addicted friends, work) which help prevent a descent into loss of control requires drug users to keep their use secret. When they have to come out into the open, these props are lost or taken away and with them the resources needed to lever oneself out of the loss of control represented by the term addiction (Sharp et al, 1991). At this stage descent into what is clinically recognised as dependence is rapid (Ridenour et al, 2003) and turning back becomes extremely difficult. The ladders are hauled up (or, to switch analogies, the doors are closed behind them), blocking a return to normality. The society which hauls up the ladders and which through stigma, criminalisation and imprisonment, pushes the addict deeper into the hole, says they are suffering from a chronic relapsing condition. The fact that we have a hand in creating and perpetuating this condition does not break consciousness. Years in prison or devoted to obtaining and consuming drugs, which illegality turns into an all-consuming occupation, leave addicts short of the training, education, work experience and contacts which others accrue, further deepening the hole from which they must climb or haul themselves out of with the aid of the ropes afforded them by services, which are generally far too thin. Where the processes which lead to excessive drugtaking persist and are the same ones which sustain it, and where these are reinforced rather than countered by social responses, the result is an ever deepening bind which we recognise as a destructive addiction. People with a strong investment in valued social and work relationships may also run into patches of excessive drugtaking, but as long as these links remain intact they exert a strong pull back to moderation which can be hauled upon by the user and by their friends. Here the relationships and processes which lead to the bad patch do not persist and become the

same processes which sustain it, and 'spontaneous recovery' is the norm.
These processes are visible in research which shows that in societies where use of a particular drug is heavily stigmatised, its regular users will nearly all be socially excluded and need to turn to treatment for help, giving the impression of a chronic condition which requires professional intervention. In the same societies, where use of a different drug (such as alcohol in Western societies) is more acceptable, most over-heavy users will still retain social links and be able to recover without formal help (Hasin et al, 2001; Blomqvist, 2002), usually at the first try (Price et al, 2001). They are diagnosably dependent, but it is not chronic and relapsing; they are also invisible to treatment-based research. That this is not a pharmacologically determined distinction is shown by research on returning Vietnam veterans, a fifth of whom reported symptoms of opium or heroin addiction in Vietnam. Though many tried narcotics on their return, very few persisted with their addiction, and the overwhelming majority avoided readdiction without treatment (Robins et al, 1980). Returning home effected changes in their lives of a magnitude which treatment would find hard to match. The social and environmental factors which led to their addiction in Vietnam were not present to sustain it on their return. The Vietnam environment had extended opiate addiction to socially integrated individuals who would not have become addicted in their normal social environments and, like socially integrated dependent drinkers within US society, they were able to exit without formal help. Veterans who before Vietnam had evidenced deviant behaviour, used heroin and other drugs, and who had drug using social circles, tended to among the few who returned to regular heroin use on their return (Robins et al, 2003). For these soldiers going back to life as usual was also going back to drugs.

Closed doors block return to normality

Further echoes of the closing door can be heard in research reports such as that investigating the efficacy of the first prison-based drug treatment program in Taiwan (Vaughn et al, 2003). Recidivism was related to problems with reintegrating into society after release some of which were aggravated by their treatment (for which they had to pay, leaving them in debt) and by their imprisonment which made them ineligible for secure loans for business ventures. Their drug abuse problems led them into further legal and family problems, presumably contributing to difficulties in employment and resettling in the family home. In the USA interviews with street sex workers and drug injectors revealed how "criminal law and policing help to transform sex work and injection drug use from activities into identities". Instead of being something they do among others (such as being parents and lovers, students or workers) the exclusive focus of the state on their drug using behaviour makes people who use drugs into 'drug users', and people who use drugs a lot into 'addicts'. They are forced to see their drugtaking as central to their identity because this is how they are treated by other people who have power over their lives, among whom are treatment personnel. If they too come to see themselves as nothing but a 'junky', the route to recovery is likely to be that much harder. Creating a new identity both in terms of one's self conception and one's social network is an important task in avoiding a return to addiction (McIntosh et al, 2000; Walters, 2000). In Scotland too, disadvantaged youngsters commonly identified drug and alcohol abuse and criminal records associated with drug abuse as holding them back from making progress in their lives, especially getting a good job (Calder et al, 2003).

An analogy with racial discrimination may help us see what could be happening. When they arrived in Britain black people had no reason to see their blackness as central to their identity, but they soon learnt that this was not how the host society saw it, that for the white people around them, their skin colour *was* the defining feature of who they were and of their capabilities. One response is also to define yourself as above all a black person, either internalising the host society's negative myopia or mirroring it the form of a positive black identity. Other resist this biological reductionism, but it is hard when encounter after encounter knocks you back to the realisation that whatever your qualifications, wealth or power, to this society you are black. In the same kind of way, drug users who can no longer stop their drug use becoming visible soon find that for the society around them this is the key feature of who they are. Sometimes too, as with race, rewards or at least the amelioration of distress are made contingent on adopting this identity. With regular and frequent illegal drug use there is the added complication that in order to access sufficient supplies it may be essential to immerse oneself in overcoming the obstacles to obtaining the drug and in the marginal social networks along which the drugs flow, making it impossible to place drugtaking in its proper perspective as just one identity and activity among many. If using cocaine or heroin is 'your thing', the society around you conspires to ensure that it becomes your *only* thing, the constriction of interests and activities seen as one of core features of addiction.

In these ways social reactions are integral to the creation, identification and maintenance of addiction and by extension, also to its ending. Addiction is an interaction between the person taking the drugs and the society around them as experienced in practice and as internalised in the individual's own judgements on their behaviour and constructions of what it means about who they are.

For Western nations the social exclusion of addicts and its consequences are too close to our eyes and their origins too far in the past to be clearly seen. They are easier to see at a distance, where the processes may also be unfolding before our eyes. Anthropologists and other researchers have told the story of how Thailand's largely successful determination to eradicate opium growing (a necessity if it was to stay on the right side of international development agencies and aid donors) was not accompanied by programmes to reduce addiction (Lyttleton et al, 2003). The result was widespread resort to injecting heroin, a better choice when times are tough both financially and in terms of law enforcement pressure. Late in the day detoxification programmes were established but addicts were blamed for their failures and excluded from their villages, further denting their self-esteem and their psychological and social resources. In some areas there was a virtually 100% relapse rate. Laos learnt from this nearby disaster when similar pressures led it to seek to eradicate both opium production and its opium addiction problem. Detoxification programmes were put in place, emphasising the evils of the drug and the economic burden created by unproductive addicts but also the need for post-detoxification communal support. However, the programmes were generally unsuccessful and addiction rates did not take the expected dive. Demonisation of the drug spilled over to the addicts who used it and the planned community support became eroded or reversed. Addicts came to be seen as a blockage to modernisation and to the fruits of development. Those who did not stay clean were stigmatised and excluded. An addict identity with the trappings of moral degeneracy emerged and those on whom the cap was fitted were driven or fled to the margins of society. A later phase of the work learnt from these

mistakes and carefully and patiently established sustainable community support structures built on the community's ownership of the process, implicit in which is the acceptance that its success too was a communal responsibility, not one that rested solely on the addict's shoulders. The addict's social network was preserved and the community supported their recovery. By the end of the second year, in these villages the relapse rate was minimal.

It is no surprise that incarceration and a criminal record decrease the resources available to someone to reintegrate into society, impeding recovery, but the same may also be true of treatment and supervision requirements so onerous or so insensitive that they interfere with addicts drawing on the supports they have, preventing the accumulation and exploitation of recovery capital. For former drug using prisoners in Taiwan, post-release parole reporting requirements conflicted with work schedules (Vaughn et al, 2003). This may also be why adding intensive long-term (three times a week for six months) treatment to the probation or parole supervision of moderate risk drug using offenders worsened arrest statistics but improved those for high risk offenders (Thanner et al, 2003). The moderate risk group may have retained social links and employment possibilities which intensive treatment prevented them drawing on, while for the high risk offenders the same treatment may have substituted for a lack of the same resources. There could be other explanations, but at the very least, the perspective developed by recovery capital researchers directs our attention to this as a possibility. The same mechanism may explain why inflexibly requiring particularly anti-social offenders to attend drug courts twice a week helped them stay drug free, but had the opposite effect in people whose social relationships were more healthy (Marlowe, 2003). They benefited most from flexible, 'as needed' hearings. A similar mechanism seems apparent in studies showing that requiring frequent attendance at treatment services (which for many would seem good practice) can be disruptive. In one US study it was associated with higher drop our rate from methadone maintenance (Rhoades, 1998) and in Switzerland the pre-existing lack of resources of patients in experimental heroin prescribing programmes was compounded by the requirement to attend for supervised consumption two or three times a day, making "a complete reintegration into the workforce ... extremely difficult" (Güttinger et al, 2003). The result was that unemployment and reliance on social benefits actually increased compared to before treatment and continued to increase during treatment.

We also create our own reality in the form of the amoral addict who cannot be trusted. In services centred on national or local targets rather than on their clients, addicts face the choice of being branded non-compliant and possibly denied help, or acquiescing with objectives they do not share or, given the resources made available to them, cannot achieve. As many of us would, they manipulate the truth to get whatever help is on offer and to avoid persecution. In this they are no different from the managers and doctors in the hospital trusts responsible for their treatment. Faced with targets which they see as impossible or illegitimate, they too may fiddle the figures.

Harm reduction first turn off the machine

Within a framework which ignores the degree to which our own responses construct and create addiction and obstruct de-addiction, conventional treatment models make sense. So *Models of Care* (and in this it is not alone) is able to discuss outreach approaches without

for once asking why it is that dependent users of illegal drugs are hard to reach in the first place, why they do not voluntarily seek treatment usually for many years after addiction has taken hold, and often not at all. Changing ourselves to destigmatise addiction, remove legal threats on users, and to provide services responsive to their individual aspirations, might be the best form of outreach we could mount. In Britain the Misuse of Drugs Act and in other societies similar socially excluding prohibitions act as a giant and well resourced harm production machine which also helps create the outsider identity of the junky and dope fiend. Documents such as *Models of Care* are about standardising the mops which soak up some of the harm and improving their soak-up capacity, while the wheels grind out far more than they can cope with. To relieve the pressure and prevent flooding of the rest of the population, small, controllable holes are punched in the prohibitions, such as allowing legal access to needles and syringes and highly circumscribed legal access to heroin, and much of the argument in the field is over where and how big these holes should be and who should control them. Turning off the machine or at least cranking it down rather than mopping more systematically round the edges may be the most cost-effective harm reduction and anti-addiction move we can make. Instead of doing things to address the problem, it might be best first to *stop* doing the things that help create it. To the proverbial observer in the helicopter, it would beggar belief that that we worry ourselves over standardising the mops and training the cleaners when it would be so much simpler to turn of the machine, but to the moppers, heads bent to the floor, this vision is unavailable and their exclusive focus on the spillage seems perfectly rational. Or, to give many drug workers their due, they all too clearly see the machine's effects but do not see stopping it as their business, and nor do those who produce the guidelines they are enjoined to follow.

Back to quality of life

Kemmesies' recipe to the irrationality of McDonaldizing drug care was a return to 'haute cuisine', in style if not in expense. The route would, he thought, take us via more serious consideration of seemingly vague objectives such as "quality of life", which might embrace substance use as a desired and valued element. The revolution this would entail is belied by the author's mild form of expression. Drug use and its negative consequences would cease to be our focus, without having to be coerced or outreached to, drug users might flock to 'accent on the positive' services devoted to making their lives better. They might even stop seeing themselves as drug users or addicts or junkies and we might do the same. If drug use was no longer seen as a legitimate target in its own right then the machinery of prohibition also no longer makes sense. We can turn of the harm production machine and devote at least some of the mops to other spillages. People will still get into trouble with drugs but our responses will no longer erode the very resources they need to get out of that hole.

Of course, it will not be that simple. Even when it comes to quality of life, there may be a tussle over whose quality and how it is to be defined, but what the concept brings to the fore is the client's 'subjective' assessment of how well they are feeling and functioning – they set the agenda. 'Hard-nosed' researchers and planners seeking 'objective' criteria such as drugs ingested, urine tests and crimes committed will sneer, but if 'medical treatment' is not at least largely about helping the patient feel and function better from their point of view, it is hard to see in what sense it qualifies for the term. It is the

subjective that matters; soft is hard, just as the softer qualities in counsellors matter more than hard qualifications. In any event, what is ‘subjective’ becomes ‘objective’ simply by asking the patient/client and recording the responses in a systematic manner. If when we do ask, the responses bear little relation to objectives embraced by research, policy, and services, we have a one sign of McDonaldization in action.

If we change the terminology a little, we can see that some of this was not just predictable, but predicted. Commenting eight years ago on the launch of Britain’s very first national drug strategy, I wrote: “If the policy takes hold, services – especially those funded from statutory sources – will no longer be able to argue for funding purely on a client-centred agenda of responding to drug users’ needs, but will have to show their relevance to national objectives which focus on primary prevention, abstinence and crime reduction” (Ashton, 1995). It was an insight for which I cannot take credit. The report was based on an interview with the civil servant responsible for putting the strategy together. With shocking candour, she said: “You realise this means the end of client-centred services.” Even when services have to or choose to become target- rather than client-centred, the client can remain doggedly centred on themselves, pursuing, as many of us do, a decent quality of life as they define it. The result is the disjunction that we started from.

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