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Voices of Experience: Attitudes and Opinions of Recipients of Unsupervised Injectable Opiate Treatment in the Northwest of England

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Summary

Aims and Methods: To describe the views and experiences of drug users receiving unsupervised injectable opiate treatment (IOT) for opiate addiction, the most common current form of injectable treatment in the UK. Semi-structured interviews were completed by 29 IOT recipients from two Community Drug Teams in northwest England.

Findings: Attitudes of most respondents were positive with personal and social benefits: reduction or cessation of illicit drug use; health gains; more "normal" lifestyle; reduced criminal activity. IOT recipients were not a homogeneous group and had different needs and goals. **Conclusions:** Individuals valued the stability IOT had brought to their lives. The treatment challenge is how to maintain stability without allowing drift into inertia. Much of the IOT debate has been led by service providers and academics. IOT recipient views have been neglected and this study adds a new voice.

Key Words: Attitudes; Injectable Opiate Treatment

1. Introduction

In the UK, injectable opiates have been prescribed as part of the management of drug dependence since the start of the twentieth century (30). Although some other countries have conducted research into the use of injectable diamorphine treatment (21, 22, 33, 34), the UK is almost alone in prescribing injectable methadone on a maintenance basis (27, 16). The number of people being prescribed injectable opiates in the UK has varied over time and across locality. There is a dearth of statistics relating to individual prescriptions. The best estimates available indicate that in 2001 injectable diamorphine accounted for 0.5% of all prescriptions for opiate dependence (28) and that, in 2005, injectable methadone accounted for just short of 2% of all methadone prescribed in England and Wales (32).

It has been argued that the decision to prescribe injectable opiates is based more on the personal viewpoint of

the prescriber than on research evidence or systematically collected clinical data (13, 36). Indeed, despite its history, injectable opiate treatment (IOT) had, until recently, attracted relatively little research interest in the UK. Of the earlier published studies of IOT, two excluded injectable methadone (6, 10) and one included only a small number on injectable methadone scripts only (2). Studies covering injectable methadone treatment (14, 15, 31) focused on comparing two or more different treatment modalities and had acknowledged design difficulties that made drawing firm and general conclusions difficult. Findings from an audit of IOT patients and a cross-sectional survey (26, 27) suggested both benefits from, and dissatisfaction with injectable methadone treatment, most of which was, and still is provided on an unsupervised basis. Recent policy interest has shifted to focus on the prescription of diamorphine (16) and on the provision of IOT under supervision. Drawing on the experience of work in the Netherlands and Switzerland (33, 21), the current Randomised Injecting

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Opioid Treatment Trial (RIOTT) study will compare supervised methadone and diamorphine injecting as well as oral methadone treatment (8).

A detailed discussion of the debate concerning IOT has been presented by Zador (36). The main rationales for IOT are harm reduction and retention in treatment. It is argued that IOT is justified when other treatments have failed and the injecting drug user's health or well-being is at serious risk (5, 36). IOT is said to provide a way of minimising illicit drug-related harm for those who are unable to respond to other treatment interventions while also retaining injectors in services until they feel able and willing to make changes to their drug using behaviour.

The effectiveness of harm reduction approaches (which encompass IOT) has been questioned (11) by pointing to the continued spread of HCV, and the impact of drug use on drug users families and host communities. Opponents of IOT argue that providing injectables merely condones and perpetuates injecting practices. The provision of such treatment is said to make the injector's behaviour even more entrenched, to take away any motivation to cease drug use and to delay significantly the decision to give up injecting (36, 1).

British policy on treatment for opiate addiction has in the past acknowledged that a small number of long term injectors may benefit from IOT (3, 17). The current UK clinical guidelines (4) maintain the 2003 recommendations that injectable heroin and methadone should be considered for a minority of individuals who are genuinely unresponsive to oral maintenance treatment. In an annexe to the guidelines it is suggested that Metrebian (16) provides evidence that "quality of care planning and treatment" for patients receiving unsupervised prescriptions is "variable and often poor" (4: 117). The advice does not go as far as recommending that all patients should be placed on the same footing; instead, current treatment should be continued but it should be reviewed regularly. The 2008 UK Drug Strategy (7) continues to include the option of "rolling out the prescription of injectable heroin and methadone to clients who do not respond to other forms of treatment".

There are many unanswered questions concerning the practice of treating opiate dependent individuals with prescribed injectable opiates. While injectable treatment is still included in the options available to clinicians, the most recent national guidelines recommend that any patients new to treatment and deemed to require an injectable prescription must have this administered in a supervised environment. This is a new departure for the UK and could in the future be seen as allowing a comparison to be done with the current unsupervised modality.

There are few readily traceable published studies on the opinions and experiences of those receiving IOT (27, 35) and both are based on structured, self-completion questionnaires. The current study used a different approach and sought to explore the recipient perspective in more depth by using a semi-structured interviewer-

administered method allowing scope for respondents to expand on their answers. More qualitative explorations such as this have not been widely used in looking at IOT (19, 20). The aim was to add a new dimension to the current debate on prescribing injectable opiates by providing information from the recipients of IOT concerning the following research questions:

- How do IOT recipients perceive the process of being put on IOT?
- Is IOT viewed as beneficial by those who are receiving it?
- Are there ways in which IOT is unhelpful to its recipients?
- Do IOT recipients think it was it the best form of treatment at the time?
- Are IOT recipients planning to come off IOT?
- Do IOT recipients want help other than their prescription from services?
- Do IOT recipients receive other help from services?

2. Methods

2.1 Study Population

The study was carried out at two Community Drug Teams within the Morecambe Bay NHS Primary Care Trust area in the north west of England between July 2002 and May 2003. Approximately 420 individuals were receiving opiate substitution treatment (with a further 110 being prescribed for by their GPs and supported by the Drug Teams under "shared care" arrangements) at the time of the study. IOT had been initiated by a variety of different doctors at different times in the history of the Service. Thirty-six of the 420 (nearly 9%) were receiving injectable opiates. The target population was these 36 individuals.

2.2 Study Instrument and Administration

A semi-structured interview schedule was devised that included selected closed-response questions used in a descriptive study of IOT in Manchester (26). The qualitative element was developed following a review of the relevant literature, discussions with experienced clinicians working in the field and informal interviews with a range of clinic staff and service users. The resulting open-ended questions covered the following topics: reasons for, and views on, being put on IOT; benefits and unhelpful aspects of IOT; views on coming off IOT; perceptions concerning help received from the service.

Ethical Approval was sought and obtained from the Local Research Ethics Committee. Following a pilot of the instrument, participants were interviewed between July 2002 and May 2003. Interviews were conducted by an experienced independent researcher (AW) who

was not associated with the clinics or with respondents' treatment. Subjects were given written and verbal information and the chance to ask questions about the study. It was made clear that participation was voluntary and that agreement or refusal to take part would not affect their treatment in any way. Participants signed a consent form. The majority of interviews were conducted in a room in one of the drug services; two were conducted in the interviewees' homes and one took place in a doctor's surgery. Length of interviews varied from thirty minutes to three hours.

2.3 Study Cohort

During the study period, 36 people receiving IOT were eligible for inclusion: 20 attending Lancaster and Morecambe Drugs Service and 16 attending South Cumbria Drugs Service. Three were discharged before they could be interviewed, one moved out of the area and three refused to take part in the study. A total of 29 subjects were interviewed; a response rate of over 80%. Sixteen participants were interviewed at Lancaster and Morecambe Drugs Service and 13 were interviewed at South Cumbria Drugs Service.

2.4 Cohort Characteristics

Twenty-one (72%) men and 8 (28%) women were interviewed. The mean age of the sample was 40 years (range 31-52). All participants described their ethnic group as "white". The vast majority (27: 93%) were dependent on social security benefits. Only 2 (7%) said their main source of income came from employment. Over half (16: 55%) were married or living with their partners, 3 (10%) were in relationships but not living with their partners and just over a third (10: 35%) were not currently in a relationship. The mean age at which respondents began injecting was 20 years (range 14-50; median 18). The mean duration of injecting any drug was 21 years (range 7-36; median 21). Twenty-five (86%) were on injectable methadone, 4 (14%) were on injectable diamorphine. All participants were injecting on a daily basis apart from one who was being prescribed ampoules two days a week and tablets five days a week.

2.5 Qualitative Analysis

Responses to the open-ended questions were audiotaped and then transcribed verbatim. Initial analysis involved reading and re-reading the transcripts and conducting a preliminary categorisation of the data. After summarising and indexing the data, emerging themes were identified and existing categories refined (12, 23). This process was undertaken separately by members of the Project Team (RL, MO and AW) and also by an independent researcher (IP). Results were compared and, after some discussion, a consensus was reached on

the main concepts and themes. Quotations were then selected to represent the range of views expressed by participants, including the untypical, whilst aiming to avoid repetition and redundancy. Interviewees' words are largely unedited.

3. Results

3.1 Reasons for receiving IOT

When asked why they had been put on IOT, participants' responses varied from one-line answers to in-depth explanations. While several suggested they had been put on IOT simply because they had "asked for it", a couple described the process as having been long and drawn out.

The majority of participants (24/29) had been prescribed oral methadone at some point prior to being put on IOT. The average length of time on methadone mixture before getting an injectable prescription was three years, with a range from 0 to 16 years. One of the most common reasons given for being moved to injectables was having a bad physical reaction to the oral preparation:

"Every time I had the green, it was a case of being sick or I ended up with ulcer burns in my mouth. I hated the taste of it. It was horrible."
[MB14, M, 32, 18, 5]

Another recurrent explanation for being moved to IOT was the practice of injecting their prescribed liquid methadone. Sometimes this behaviour was linked with, what participants called, "needle fixation":

"I couldn't handle the linctus cos I was picking it up and I had a needle fixation and I was injecting the linctus and it's dangerous so that's why they ended up putting me on the injectables." [MB11, F, 31, 17, 6]

An equally common though more vague theme was that oral methadone "was not working" [MB1, M, 36, 19, 2] or "wasn't doing anything for us" [MB10, F, 34, 16, 6]. As one participant put it:

"The oral wasn't enough. It was sorting me bones out but my head was still buzzing."
[MB16, F, 52, 11, 1]

Others put it in more specific terms: "I wanted to get the hit faster." [MB6, M, 32, 16, 14]

The frequency with which they had been injecting illicit drugs was also seen as a major reason for being put on IOT.

While the term "harm minimisation" was not used, many indicated that it had played an important part in the decision to prescribe injectables:

"If they'd given me the mixture I would've injected that so it was safer I suppose to give me the amps... I was injecting a lot and my arms were quite bad at the time you know." [MB2, M, 37, 21, 10]

"If she hadn't put me on it I would've ended

up dead. I'd ended up in hospital a couple of times with blood poisoning and phlebitis." [MB29, F, 42, 23, 12]

3.2 Perceived benefits of IOT

Asked how IOT had helped them, most participants perceived a variety of benefits. These ranged from the dramatic: *"It's stopped me from dying or killing myself"* [MB2, M, 37, 21, 10] to the less vivid: *"it gives me a sense of security"* [MB8, M, 44, 23, 10]. Comments like *"it's changed my life completely* [MB24, M, 48, 31, 20]" were not uncommon.

From their accounts it was clear that IOT had helped participants to cease or significantly reduce heroin and other illicit drug use. This was borne out by examination of each user's reports of past drug taking and current drug taking. Several stressed the point that if they had not been put on IOT they would still be injecting either "street gear" or oral methadone.

"I'd either be dead or in prison if I wasn't taking these drugs. I would definitely have carried on injecting. I have no doubt in my mind." [MB3, M, 50, 33, 30]

"it has kept me off street drugs for long periods of time. If I wasn't getting them, I would probably be doing smack every day. I just know I've benefited from it. I don't know." [MB12, M, 32, 16, 10]

IOT helped some because it meant they no longer had to mix with certain people:

"I have met people I didn't even know existed. People wrecked out their heads with heroin. I'd never seen stuff like that in my life, now I'm on an injectable script, I can keep away from it. No one knows I'm on it. It gives you a bit more pride. I feel very anti-heroin now." [MB22, F, 38, 13, 7]

Hand in hand with this response, it was often stated that IOT had given them a chance to lead a more "normal" or "stable" life:

"I was a single parent for years looking after my children and it helped me to get on and have a life. Get up, get my daughter ready and take her to school and come back and go to the chemist. It helped me have a normal life. I get into the garden, do whatever instead of just spending all my time out stealing and lying and cheating." [MB18, M, 38, 23, 10]

"My life is a lot calmer now. I don't have to spend all day running around looking for gear. The drugs I used to take would make me out my head. I'm a lot calmer now. I'm allowed to see my children now, when they come over, they stay now. I don't know where I'd be actually now if I hadn't got on this prescription." [MB25, F, 41, 14, 10]

"Just knowing that it's there and I'm not having to run out and I can spend time with my family instead of chasing drugs. It gave me the time to have quality time with my mother. It's helped me with looking after my father." [MB19, F, 44, 28, 9]

Not having to commit crimes to fund their drug use was perceived as a very important benefit by many. Several said they would have been serving custodial sentences if they had not been given IOT:

"It enabled me to live a reasonably normal life without ending up in jail for the last 15 years. In the last 15 years, I've not been in trouble for anything." [MB15, M, 46, 30, 15]

"It's took a lot of weight off me shoulders... I don't have to do any bad things to get money or anything. The money I get is just mine, for food and whatever I want. It really has helped me." [MB16, F, 52, 11, 1]

Some participants were emphatic that, without IOT, they would be dead. Less extreme health gains were noted:

"I look after myself a lot better. I'm a lot healthier person. And not only that, I'm getting constant medical attention as well, you know, and care. Which before I wasn't. When you're using street gear, you don't go to the doctor at all for anything." [MB29, F, 42, 23, 12]

For four, who had problems with chronic pain, an important beneficial effect of IOT was its pain relieving properties.

3.3 Ways IOT had been unhelpful

There were ways in which IOT had been unhelpful. The dominant concern was not with the treatment itself but with the way it was administered. Participants complained that prescription collection severely restricted their movements:

"It ties you down. Having to pick it up every day. You can't just get up and disappear for a week. Get a holiday. You have to be there 9.15 every morning." [MB18, M, 38, 23, 10]

Several participants complained about how difficult it was to get off injectable methadone:

"If I'd known all this shit was going to happen it would've been easier to get off street gear. It's easier to get off street gear than methadone. Methadone gets into your bones. The only way to alleviate it is to get sun into your bones. I feel cold even if my body seems warm." [MB4, M, 51, 36, 11]

"I get really annoyed with myself for taking it because it doesn't do anything for me. All it does, it makes me feel normal. I don't get stoned off it. it's the dependency really - dependency on the drug. The withdrawal from methadone is very severe and I find that the longer I take them,

the quicker I get ill in the morning." [MB15, M, 46, na, 15]

A range of other issues was raised including problems with profuse sweating and serious concerns about the effects of IOT on the veins. One participant said it had interfered with his sex drive and that this was causing difficulties in his relationship.

3.4 Thinking about coming off injectables

When participants were asked if they thought they would reach a stage when they might consider coming off injectables, responses tended to fall into three broad groups.

The first group was currently reducing their prescribed doses. Some were doing this in a planned way with a definite end date in mind:

"I'm doing it now. I'm reducing now. You've got to want to do it yourself. It's up to me. I'm going on holiday next March so my plan is to get off it by then, for when I go away." [MB11, F, 31, 17, 6]

Others were reducing over a longer time period with no set date for coming off:

"Soon. In the next year or two I'll probably be off it. It's only the last year that I've been reducing. I've come down 50 mls so far. I do get help off a counsellor and he listens to what I say and we compromise about the best thing to do. I reckon I'll be off it in the next year or two definitely." [MB13, M, 32, 7, 6]

The second group said that they thought they would reach a stage of coming off but dates and timescales were usually indeterminate:

"Yes, hopefully not too far away. It depends on the situation. If something turns up and I've got a good incentive to change me habits, then hopefully I'll be able to do it." [MB4, M, 51, 36, 11]

"I'll be ready to come off one day but not in the near future. I need to get my life sorted out. I'll know when." [MB7, M, 33, 13, 10]

"Obviously, there's going to be a stage when I'm going to come off. I don't really know. I don't want to be an old man having to shove needles in my body." [MB12, M, 32, 17, 10]

"yes. Every day I make a little promise to myself. I got goals. I started with that job and I had all good intentions to carry on with it. Getting up and putting on a shirt and tie was hard but if I could manage it for two months then I could stop the amps; maybe be on pills like my wife. If I don't get it, I don't miss it. I don't just get up for my methadone in the morning. I don't go to the chemist till the afternoon to get it. I don't bother with it until the evening and I wonder why I am bothering. It's just that little bit of

security. Because I always get anxious just after my son goes to bed at about 830 to 9 o'clock. I get anxious. I start thinking too much. I draw a lot to keep my mind off it. When I was at work I was too tired to think about it. I enjoyed work. I drive her mad at home. I'd work for the same money you get on the dole. You don't meet anyone at home do you? I hate going to work but once I'm there I like it." [MB8, M, 44, 23, 10]

The third group comprised individuals who said they could not envisage stopping injectables. Some put this down to an inability to give up adding that they would only come off if forced to:

"There will probably be a time when I come off when my body will make me come off. If I could stay using but they said I'd die in the next 6 months then, of course, I'm going to go for something else. I'd only come off if I had to." [MB27, F, 51, 35, 34]

Others put it in terms of choice:

"Ideally, I'd like what I'm on now to take me through. I know of people in their 60s and 70s who have been using methadone in London and are still going strong. There is the possibility of the injection site getting traumatised but other than that, the actual drug ... I really think there is more damage from smoking and alcohol." [MB24, M, 48, 31, 20]

3.5 Was IOT the best form of treatment

The majority of participants said that, looking back, IOT had been the best form of treatment for them at the time and some stated they should, in fact, have been put on IOT earlier. Comments from those who said IOT had not been the best form of treatment included complaints about the type of opiate they had been prescribed and that detoxification would have been a preferable option although this participant admitted that "I don't know if I would have gone or not" [MB14, M, 32, 18, 5]. Some participants were ambivalent. As one put it:

"Yes and No. Yes, because it got me through some really bad times but no, because I didn't think I'd be doing it this long." [MB8, M, 44, 23, 10].

3.6 Other help received from Service

Participants said they had valued help, other than their prescription, received from the Drug Service. The main type of help was variously described as: "someone to talk to", "someone who listens" and "support". Two said they had received "counselling". The degree of importance placed on this kind of help ranged from people who saw it as relatively peripheral - "The script is the main thing but it's nice to talk as well" [MB28, M, 42, 12, 6] - to those who perceived it as being central to

their existence:

“Over the years, I’ve lost my kids, my home and everything over drugs. I don’t know what I would have done without someone to talk to in here. It’s the only place you can go really if you need to talk to someone.” [MB25, F, 41, 14, 10]

“Apart from my addiction, [Key worker] has been there and even though I’ve had other relationships in my life, I’ve moved, I’ve done things - he’s been a constant in my life for the last ten years. I can tell him anything.” [MB29, F, 42, 23, 12]

A number of participants talked about assistance with practical problems:

“He’s tried to help me and he has helped me a lot. Getting housing and that, letters of support and that.” [MB6, M, 32, 16, 14]

“Yes. Well, problems like doctors’ appointments. It can get very hard to get them. [Key worker] will phone around for you. They help with just about anything really if you ask them.” [MB26, M, 45, 27, 10]

“He’s helped me with everything. With my children, with housing, with social security, sickness benefits. At times, I get really bad agoraphobia and that’s when things go wrong. [Key worker] is good at helping sort out my housing benefit.” [MB29, F, 42, 23, 12]

There were those who said they had not, in fact, required any other help from the Service:

*“I have not needed help. I can’t wait to get off it. It feels like they are playing God with my life and I don’t like it. The attitude is “f*** them, they are only drug addicts”. [MB4, M, 51, 36, 11]*

Several pointed out that they would rather not have to attend the Service although a couple of them made contradictory statements:

“I’m sorry, but I’ve got no choice. I’d rather not have to come. I’m glad, I come sometimes. I build stuff up and some days I’ll be more happy and everything and some days, like today, I feel shit.” [MB14, M, 32, 18, 5]

3.7 Help wanted from Service but not received

While some said they had got all the help they had needed or wanted, there was a range of complaints from others.

Several were unhappy about the lack of access they had to Drug Service staff:

“I find the service does not provide an adequate in, off-the-street service. If you’ve got an immediate problem there is no provision for helping you here. There’s no one on standby, no nurse, no one who can write a script on

standby.” [MB3, M, 50, 33, 30]

“When I first started here... they had loads of time and you could go in and see them whenever you wanted and if you had a problem you could talk to someone. If I phone up now they are always busy or in a meeting. I leave messages and they never seem to get passed on. I don’t blame them for it, I can understand how busy they are and how many people they have to see.” [MB15, M, 46, 30, 15]

Three participants reiterated previous complaints about their prescription dose or type. Other kinds of help not received included: a lack of support or understanding from a key worker or doctor; more help with after-care; the service not being orientated towards self-help.

4. Discussion

The prescribing of injectable opiates is a controversial treatment option. While the debate concerning the rights and wrongs of IOT continues (36,5,11), it is surprising that such scant research interest has been paid to the experiences and views of those on the receiving end of this intervention. The aim of the current study was to explore IOT from the recipient’s perspective. The results show that those receiving IOT in the Morecambe Bay NHS Primary Care Trust area between July 2002 and May 2003 area were not a homogeneous group of people. There was a wide range of attitudes to, and perceptions of, IOT.

Reasons for being put on IOT were not always clear in individual cases but harm minimisation played a large part in the decision. The majority had initially been prescribed oral methadone but for a variety of reasons they said they could not give up injecting. Attitudes to receiving IOT were overwhelmingly positive with many personal and social benefits noted including: a reduction or cessation of heroin and other illicit drug use; a range of health gains; leading a more “normal” lifestyle; and not having to commit crimes. The vast majority had no hesitation in saying that, looking back, it had been the best form of treatment for them at the time.

Attitudes to coming off injectables were varied. Some were actively reducing their doses with the aim of abstinence. The largest group said they planned to stop but timescales were usually vague. Others stated they had no intention of coming off unless forced by service providers or other circumstances and a small minority said they would choose to stay on injectables indefinitely.

Many said that they had received help in addition to their prescription. The value placed on this help ranged from those who saw it as being “nice to talk” to those who perceived it as having been crucial to their survival. Several said they had neither wanted nor needed help other than their prescription. A few insisted that they would rather not have to come to the service.

The results of the study show that there were clearly distinguishable extremes of opinions and attitudes to

IOT with a range of views between these positions. At one extreme, were those who perceived themselves as having significant psychological and social problems in addition to requiring an injectable opiate prescription. They felt that they had needed, and continued to need, a great deal of support and help from the service. IOT was viewed as treatment. Both the prescription and the input from service staff were of central importance. IOT, they said, had literally saved their lives. They wanted to come off injectables at some stage in the future but were fearful about making this change.

At the other extreme were individuals who did not perceive themselves as having problems other than needing access to free, pharmaceutically safe, injectable, opiates. The main benefit of IOT was not having to commit crimes in order to purchase street heroin. Their main complaint concerned the restrictions that collecting their prescriptions placed on their personal freedom. They did not see themselves as needing or wanting help other than their opiate prescription. They did not perceive IOT as being "treatment". They would rather not have had to come to the service and only came in order to get an opiate prescription. They would choose to stay on injectable opiates for the rest of their lives.

In spite of the differences in research approach, some results from the current study were similar to those found by Sell and Zador (27). Participants in both studies reported problems with previous oral methadone treatment in terms of it making them vomit, disliking the effect and the continuing desire to inject. In each study the benefits of IOT included: keeping out of trouble with the police; helping with family relationships; having a drug supply of known dose and purity; improvements to health. Participants tended to perceive IOT as a long-term intervention. Coming off injectables was often viewed as something to be done in the indeterminate future and some wanted to stay on them indefinitely.

In the current study many had been receiving IOT for a long period of time. Some of those interviewed said they had never made a serious voluntary attempt to come off IOT. It could be argued that these findings lend support to the view that the provision of IOT makes injecting practices even more entrenched. Equally it could be argued that, without IOT, this group would have carried on injecting with all the attendant risks of illicit drug use. While the exact personal and social cost in terms of criminal activity, incarceration, family break-up, health problems and even deaths that may have ensued had they been refused injectables cannot be known, respondents themselves felt that the costs would have been high.

Retention in treatment is seen as key to achieving more positive treatment outcomes (18) and it is acknowledged that IOT is a long-term intervention requiring long-term commitment from services (24). It was clear that many valued the stability that IOT had brought to their lives and the reluctance to give up injecting may reflect the fear of jeopardising that situation (25). However, the challenge

is how to maintain the stability gained through treatment retention without allowing it to drift into inertia (25). This study indicates that ongoing IOT with its multiple components did not result in inertia in this challenging group but allowed some to make positive progress. As Strang (29) pointed out the ambivalent drug user's motivations may alter over time and services need to work to exploit the resolve to change by providing the most appropriate intervention at any given time.

The findings from this study cannot provide answers to questions concerning the optimum service delivery of IOT. However, many respondents valued the relationships they had developed with staff and clearly valued the "support" they had received in addition to their injectable opiate prescription. The NTA (18) has acknowledged the importance of empathy and support in establishing better rapport with service users. Involving service users is crucial to providing relevant, successful interventions.

This study of one treatment service highlights the fact that those receiving IOT were not a homogeneous group but comprised individuals with differing needs and goals. Services must be adequately resourced, skilled and responsive in order to work with people who have different motivations and a varied readiness to act. How services work with those who do not view IOT as a treatment or are even openly antagonistic towards the idea of treatment, poses a difficult question that is beyond the scope of this paper to address.

This study was based on all recipients of IOT within one UK NHS Primary Health Care Trust. Clearly, the characteristics of the subjects and of the drug services within that Trust may differ from those in other parts of the country so the findings cannot be generalised to all those receiving IOT in the United Kingdom. Also, the majority of subjects were prescribed injectable methadone and only a few prescribed injectable diamorphine. This study cannot therefore comment authoritatively on current debate in UK and Europe about heroin prescribing. However, a major strength of this study is that it allowed IOT recipients to talk about issues that were relevant to them in their own way. Much of the debate concerning IOT has been led by service providers and academics. Although IOT recipient needs are mentioned, their actual views are rarely documented. The findings from this study add a new dimension to the IOT debate.

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Conflict of Interest

The authors have no relevant conflict of interest to report in relation to the present study.

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