

## **Methadone versus subutex: Recovering heroin users' views on substitute prescribing.**

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With thanks to everyone at the Burton Addiction Centre

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## **Abstract**

Very few studies have considered heroin users' views on substitute prescribing, in particular with regards to subutex. The aim of this study was to conduct detailed qualitative analysis, using the Grounded theory approach, on heroin users' views on substitute prescribing, paying specific attention to methadone and subutex. Semi-structured interviews were conducted with nine subjects recruited from an abstinence-based, structured day care treatment program. All of the subjects were either currently on a subutex prescribing program, or had remained abstinent from illicit substances following the completion of a subutex treatment program. Five major themes emerged from the analysis. These were reasons for obtaining a methadone prescription, experiences with methadone programs, views on methadone, views on subutex and views on an ideal opioid treatment program. Most of the findings were supported by previous qualitative studies such as that of Neale (1999a) and Fischer and colleagues (2002). However, there does appear to be some discrepancies between qualitative and quantitative research with regards to consumer satisfaction of methadone, in comparison to subutex, as a substitute drug. This study clearly highlights the need for further research into users' views on substitute prescribing, with emphasis being placed on qualitative research considering users' experiences with subutex.

## **Methadone versus subutex: Recovering heroin users' views on substitute prescribing.**

Opioid dependence can be classed as a chronic and relapsing disorder, and develops due to the repeated administration of opioids such as heroin (Dole, 1988; McLellan et al, 2000). Due to this repeated exposure to opioids, profound neurobiological changes occur, which are best treated with behavioural interventions combined with pharmacotherapy such as methadone or buprenorphine (subutex®) (Ball and Ross, 1991; O'Connor and Fiellin, 2000; Sees et al, 2000). The prevalence of heroin use in Britain is extremely difficult to determine due to the nature of the drug, and the stigma surrounding heroin dependency.

The extent of illicit drug misuse in Britain is an area of keen interest for Government policy, the media and the public. The 2002/3 British Crime Survey (BCS) reported that of all 16-59 year olds in Britain, 12% had taken an illicit drug and 3% had used a Class A drug in the last year. This equates to four million illicit drug users and one million Class A drug users in Britain. The results of the BCS also illustrated that drug use was generally higher in 16 to 29 year olds with 50% reporting illicit drug use in their lifetime. Men were also more likely to report the use of illicit drugs than women, and for the whole sample (16 to 59 year olds), the proportion of men to women having ever reported the use of drugs was 40% to 28% respectively.

Prevalence rates for particular drugs varied considerably by region, with London having consistently higher rates than other regions for 'any drug', Class A drugs, cocaine and ecstasy. An analysis of different types of residential neighbourhoods showed uniformly higher levels of drug use among 16 to 59 year olds living in affluent urban areas for 'any drug', cocaine and Class A drugs. However, the rate for heroin use was notably higher in the poorest income group (3%) in comparison to the intermediate and richest groups (less than 0.5%). Metrebian (2001) estimated the population of heroin users within Britain to be between 150,000 and 270,000, a figure considerably higher than that reported by the BCS. However, the BCS is a self-report survey so it is thought that the figures obtained from the survey are underestimated due to the nature of the drug and the stigma surrounding heroin use.

The Government reported that in 2002 heroin, crack and powder cocaine users were responsible for 50% of crimes such as shoplifting, burglary, vehicle crime and theft, and that approximately three quarters of heroin and crack users claims to be

committing crime to feed their habit. It was also reported that arrestees who use heroin and /or cocaine commit almost ten times as many offences as arrestees who do not use illicit drugs. The Government have estimated that drug misuse gives rise to between £10 billion and £18 billion a year in social and economic costs, with problematic drug users accounting for approximately 99% of these costs, and on average the annual economic cost per user is approximately £10,400 per year (Government report, 2002).

Recent emphasis from the Government on the improvement of substance misuse treatment agencies has resulted in investments in treatment services increasing from £234 million in 2000/1 to £401 million in 2003/4, while the number of people entering treatment programs has been increasing by approximately 8% a year since 1998. Between 2000/1 and 2001/2, the number of vulnerable young people receiving treatment or support for drug problems in England and Wales increased from 16,939 to 35,503 (DAT returns, April, 2002). The Government estimate that for each £1 spent on treatment services, £3 is saved in criminal justice and victim costs of crime, and the longer the problematic user remains in treatment, the greater the savings ratio becomes (Government Report, 2002).

There are a number of harms associated with drug injecting, such as the transmission of blood-borne infection (McKeganey and Barnard, 1992) and drug related crimes (Hough, 1996). Prompted by concerns about a rapid spread of HIV infection dating back to the 1980's among intravenous drug users, there has been an expansion of innovative harm reduction strategies in Britain, such as substitute prescribing programs, community based needle and syringe exchange schemes and outreach drug services (Stimson, 1995).

For people dependent on illegal drugs such as heroin, the prescribing of substitute drugs is a very significant, albeit controversial (Godfrey and Sutton, 1996), aspect of harm reduction, that has become an integral part of many drug treatment strategies (Willis, 1991). Although abstinence remains the ultimate goal of substitute prescribing programs, where this is not achievable interventions now focus on risk reduction, harm minimisation and intermediate service aims (ACMD, 1988; McKeganey and Barnard, 1992). The value of substitute prescribing has been endorsed by Government reports (ACDM, 1993; The Task Force to Review Service for Drug Misusers, 1996) and it has been argued that harm reduction initiatives, including

substitute prescribing, lessen the social, medical and economic cost of illegal drug use to users and to society at large (Stevenson, 1994).

Methadone is a synthetic opioid which has been used to treat heroin addiction for over thirty years. Methadone can be used for either detoxification or maintenance programs and it is currently, in Britain, the most common substitute drug used for the treatment of opiate dependency (Strang et al, 1996). Methadone has proved to be an effective substitute drug for opiate addiction for a number of reasons, including its long half- life resulting in it only having to be consumed on a daily basis, unlike heroin which has a short half-life thus having to be consumed numerous times a day to prevent withdrawal symptoms. As methadone is also available in liquid form it deters injecting behaviours, thus reducing the risk of disease transmission.

Metzger (1993) studied 103 out-of-treatment intravenous opiate users and 152 opiate users receiving methadone treatment. It was reported that eighteen months later 22% of the out of treatment cohort had contracted HIV whereas only 3.5% of the in-treatment subjects had contracted HIV. Methadone effectively eliminates withdrawal symptoms without reinforcing the use of opiates as it has relatively little euphoric effect (Schafer, 1997). Numerous researchers have produced compelling evidence that methadone programs reduce the rates of illicit drug use, injecting behaviour, criminal behaviour, other HIV risk behaviours, overdose and death among treatment participants (Gronbladh et al, 1990; Pottieger et al, 1992; Bertschy, 1995; MacGaran et al, 1997).

Although methadone does have many positive attributes, over the years a number of negative factors have emerged. One major problem associated with methadone programs is the ease of which the methadone can be abused and in particular the ease of using it intravenously (Bertschy, 1995; New York Times, February 9, 2003; pp1). The injection of oral methadone is widespread in some areas of Britain (Darke et al, 1996) and methadone leaked from prescriptions has been reported to be heavily implicated in drug deaths (Bentley and Busuttil, 1996; Johnston, 1996). Methadone maintenance programs have been associated with a number of problems including limited community and patient acceptance (Kolar et al, 1990; Schottenfield and Kleber, 1995), and in general clients possess negative views of methadone and methadone programs based on their own personal experiences as well as what is heard from others (Flaherty et al, 1980; Koester et al, 1999; Hunt et al, 1986). Many studies have noted that among heroin users methadone has a bad reputation for

greater addictiveness, side effects and overdose risk than heroin (Beschner and Walters, 1985; Hunt et al, 1986; Rosenblau et al, 1991). Rettig and Yarmolinsky (1995) illustrated clients' negative views on methadone programs when they reported that a third of clients leave treatment within the first year. This finding was supported by other researchers who noted that only 20-50% of those who begin treatment continue on successfully for a year or more (Bertschy, 1995; Hubbard and Marsden, 1986).

Alternative pharmacotherapies, such as subutex, have been proposed to be more effective than methadone, and also cause less limiting hypotensive side effects and adverse events for the drug user (Bearn et al, 1996; Kahn et al, 1997; Kosten and McCance, 1996). Subutex was licensed for use in Britain in 2001 and is suitable for either detoxification or maintenance programs. It exerts sufficient opiate effects to prevent or alleviate opioid withdrawal symptoms, but produces a milder, less euphoric and less sedating effect than high doses of heroin or methadone (Birtwistle, 2004). Subutex has unusual properties in that it is a partial opioid agonist and a partial opioid antagonist; thus, there is a lower risk of overdose and an easier withdrawal process than methadone (Robertson et al, 1993; Cheskin et al, 1994). Subutex is also a safer substitute drug as it does not depress the central nervous system as severely as methadone; thus, death from subutex alone is extremely rare (Eder et al, 1998). A study in France noted that the death rate per patient treated with methadone was 0.0007 compared with 0.0002 for subutex (Auriacombe, 2001). When put into context, these results show that if all of the patients receiving substitute prescriptions were on methadone then the death rate would have been 288 whereas if they had all been on subutex the death rate would have been 46 (Auriacombe, 2001).

Subutex also has a longer half-life than methadone so, potentially, dosing could be given three times a week as opposed to daily with methadone (Johnson et al, 2000). Thrice weekly dosing would reduce the costs of maintaining an opioid dependent person, as well as reduce the disruption caused to the life of the drug dependent individual. Mattick and colleagues (2003) reported that less than daily dosing of subutex would seem to combine effectiveness with patient convenience, and may carry some cost savings for the patient and the health system by reducing the frequency of attending for dosing and increasing the capacity of the treatment service. Research has established that subutex blocks the effects of exogenous opioid administration (Jasinski et al, 1978), suppresses heroin self administration

(Mello et al, 1981) and reduces the severity of withdrawing from opiates (Mattick and Hall, 1996). Fiellin and colleagues (2004) posited that the use of subutex for medical withdrawal from opiates can serve to initiate and engage patients into continuing addiction treatment due to its shorter term medical withdrawal in comparison to longer term treatments such as methadone programs.

Subutex is absorbed via the sublingual route (Lewis, 1985), which means that clients have to be supervised for several minutes to prevent abuse of the drug. This process is not only time-consuming, but is expensive to maintain on a large scale. To circumvent the issue of the abuse of subutex, a new combination of substitute drug has been devised, which combines subutex and naloxone. Naloxone is an opioid antagonist that causes immediate and severe withdrawal symptoms when taken intravenously. However, it is inactive when taken orally (Robertson et al, 1993). Clinical trials are currently being conducted to determine the most effective ratio of subutex to naloxone (Strain et al, 2000), and are likely to result in a take home product with characteristics of low abuse liability, low diversion potential and diminished risk of overdose in non-tolerant patients (Gossop et al, 1999).

There have been numerous studies comparing the effectiveness of subutex against methadone. However, the results are varied and in many cases inconclusive. Johnson and colleagues (1992) compared doses of 8mgs of subutex against 20mgs and 60mgs of methadone. It was reported that 8mgs of subutex was superior to 20mgs of methadone and equal to 60mgs of methadone with regard to retention in treatment. Subjects in the subutex and high dose methadone groups were noted to have similar numbers of opioid negative urine samples, and both were superior to low dose methadone. These results were supported by Strain and colleagues (1994). However, studies using higher doses of methadone (80mgs) have reported that methadone is superior to subutex (8mgs) (Ling et al, 1996).

A number of randomised clinical trials have reported that subutex and methadone are equally effective in the treatment of opioid dependent patients (Johnson et al, 1992; Strain et al, 1994; Johnson et al, 2000; Pani et al, 2000). Ahmadi (2003) reported that the retention rate in treatment of subjects on 8mgs of subutex was 68.3% which was superior to the retention rate for subjects on 30mgs of methadone which was 61%. However, an equivalent number of studies have reported inferior results for subutex with regard to retention in treatment and opioid negative urinalysis (Kosten et al, 1993; Ling et al, 1996; Schottenfield et al, 1997; Fischer et al, 1999; Petitjean et al,

2001). Eder and colleagues (1998) noted that subjects on subutex provided a greater proportion of negative urine samples. However, retention in the subutex group was significantly lower than that of the methadone group.

Interestingly, it was noted that subutex was clearly more effective in the more motivated individuals in the study. This is supported by McIntosh and McKeganey (2002) who reported that participants expressed the importance of giving up heroin 'for yourself', as it was noted that individuals who were seeking treatment for the sake of others were less likely to complete their treatment. The inferiority of subutex reported in the aforementioned studies has been attributed to the dose of subutex being too low, or a too slow induction onto low doses of subutex (Mattick et al, 2001).

A number of meta-analyses have been conducted comparing the effectiveness of subutex and methadone, including that of West et al (2000). It was reported that there was relative equality in subutex and methadone efficacy, although the participants on methadone were less likely to have opioid positive urine samples. It was also noted that those subjects who had had past experiences with methadone were more likely to be drug free on the subutex treatment. Mattick and colleagues (2002) carried out a meta-analysis of thirteen studies and concluded that subutex in flexible doses was less effective than methadone in retention rates in treatment. It was also reported that high dose subutex does not retain in treatment more patients than low dose methadone, although it was found to suppress heroin use more effectively.

A number of researchers have reported than an equal, or greater, proportion of substance misusers overcome addiction without formal treatment, as those who do recover following treatment (Waldorf and Biernaki, 1979; Cunningham, 1999). However, the importance of treatment has been emphasised in studies such as that of McIntosh and McKeganey (2002), and it has been suggested that treatment may have the ability to catalyse and support natural processes of recovery (Edwards, 2000). This is supported by Prochaska and DiClemente's (1992) model of change which posits that an individual has to be ready to overcome their addiction, otherwise no interventions will affect their behaviour.

Researchers have long neglected the user's perspective and experiences in assessing drug effects and drug use. In recent years, there has been a slight movement towards considering the user's views of the available treatments for opioid



addiction, with attention being placed on the views and experiences of methadone and methadone programs. Recent work, such as that of Neale (1998, 1999a, 1999b) and Fischer and colleagues (2002), has been leading the field in qualitative research into the users views of available substitute prescribing drugs and services.

Sell and Zador (2004) conducted a survey that considered heroin dependent individuals most frequent reasons for seeking a prescription for injectable opiate treatment (IOT). The three most commonly stated reasons for seeking treatment were to obtain a drug supply of known dose and/or purity (74%), to help family relations (74%) and to avoid trouble with the police (74%). However, only 20.2% of the subjects stated that to stop using drugs altogether was a reason for seeking treatment. These findings are in contrast to the qualitative study conducted by McKeganey and colleagues (2004), which reported that 56.6% of their sample sought treatment to obtain abstinence from illicit drugs, whereas only 14.5% cited harm reduction as their aspirations for treatment. Neale (1999) noted that heroin dependent individuals' main reasons for seeking substitute prescriptions were to change their life style, to alleviate physical pain, to reduce harm-related drug behaviours, for illegitimate use, due to a lack of access to illicit drugs, or as a general coping strategy.

In addition to the heroin-dependent individuals who voluntarily enter methadone programs to achieve abstinence, and those that are ordered into treatments by the courts, there are a large number of opioid users who enter methadone treatment with other objectives in mind (Wall, 2001). These can include short-term goals that do not necessarily equate with complete abstinence from heroin, such as stabilising one's life, reducing health related risks, taking 'time out' and getting one's habit under control (Koester et al, 1999). The role that heroin plays in opiate-dependent individuals lives, combined with the negative physical, psychological and socially stigmatising aspects of methadone, may provide insight into the multiple factors that may dissuade individuals from embracing methadone programs (Stephens, 1991; Agar, 1973; Rosenbaum, 1983). By 'pilot testing' methadone programs, and experiencing drug free treatment episodes, clients may be encouraged to seek treatment for a more permanent basis at a later date (Biernacki, 1985). Koester and colleagues (1999) reported that heroin users recognise the different levels of success depending upon the reasons they entered treatment. For example, short term abstinence from heroin, or a reduction in heroin use, may have significant effects on the quality of life and health benefits for the individual.

Fischer and colleagues (2002) studied heroin dependent individuals' views on, and experiences with, methadone programs. It was reported that clients felt that the programs were too controlling, too inconvenient, the waiting periods for receiving treatment were too long, there were limited options available, and a lack of individualised treatments alongside a lack of staff understanding. Edwards and colleagues (1997) noted the importance of between-person variations within treatment research, and emphasised the point that a treatment program that may encompass the needs of one individual may not be suitable for another individual's needs. Sell and Zador (2004) reported that subjects felt that methadone programs 'helped for a while' (44.2%), and 'helped me gain some control over drug use' (46.2%). However, the subjects also held negative views of methadone programs, in particular that the doses were too low (39.4%), methadone was not provided for long enough (12.5%) and that they did not like the effects of the methadone mixture (40.2%).

Neale (1999b) studied users' perspectives of substitute prescribing conditions and noted that, in general, urinalysis did not appear to be a major condition imposed by prescribers. However, a number of participants considered it a useful method of keeping track of the abuse of illicit drugs, and some thought that it should be enforced more frequently. Neale also reported that subjects felt that counselling was a vital compulsory condition of substitute prescribing, although the subjects in the study had in general, only received counselling once or twice a fortnight whilst in a methadone program. Fiellin (2002) conducted a study that highlighted the importance of counselling in opiate treatment programs. It was reported that, with regards to completion of treatment, only 31% of subjects receiving methadone alone remained in treatment, whilst 59% of subjects receiving methadone alongside standard counselling remained in treatment. A final group of subjects received methadone as well as enhanced counselling, and it was reported that 81% completed their treatment. Fiellin and colleagues (2004) posited that concurrent counselling and support services are important and necessary components of treatment, especially early in the treatment process. Neale's (1999b) study also noted that subjects felt that GPs should enforce stricter rules in the prescribing of methadone, and that the collection arrangements for prescriptions were viewed very negatively, in particular the inconvenience of daily pick-ups, difficulties in arranging holidays, and everyone in the pharmacy knowing the individual's business.

Many heroin dependent individuals have tried methadone programs, often multiple times, but leave treatment prematurely, whilst others would not consider it as a worthwhile treatment option for themselves (Beschner and Walters, 1985; Kuo et al, 2000). Many users of methadone treatment programs have reported reservations about the use of methadone as a substitute drug. For example, Koester and colleagues (1999) reported that subjects had a number of negative view points on methadone, in particular there were serious concerns over its addictiveness and the painful withdrawals experienced when being weaned off the drug. The study also noted that subjects were apprehensive of the control that methadone has over an individual's life due to the daily collection of prescriptions.

Neale (1998) reported that users' perspectives of methadone were very negative, with most concern being associated with the addictiveness of methadone and how it caused similar, or worse, problems than heroin. The subjects also expressed concern over the impact of methadone on their physical and emotional health, as well as negative consequences on their financial circumstances and personal relationships. The potential for the abuse of methadone was also a concern expressed by the subjects. Fischer and colleagues (2002) reported that the major concerns expressed by methadone users were the negative physical effects, the negative effects on lifestyle and the ease of abuse. However, the most common concern about methadone was that it was viewed as more addictive than heroin and that the withdrawals were worse than for heroin.

Throughout the studies that have considered the users views on methadone and methadone programs, the users' views on desired changes to current treatment programs have emerged. Sell and Zador (2004) reported that relatively low levels of satisfaction of methadone treatment programs were reported, with 59.6% of participants wanting immediate changes to the structure of treatment programs. Fischer and colleagues (2002) reported that subjects wanted enhanced harm reduction schemes and more choice and freedom in the design and course of treatment. Subjects also expressed that one-to-one counselling should be mandatory and that emphasis should be placed on learning non-drug related life skills and hobbies.

Vaillant (1996) proposed that addiction may be overcome if changes are made to the individuals' life circumstances and lifestyles. This is supported by a study conducted by Robins (1993) who reported that the majority of servicemen, who became

addicted to heroin whilst fighting in the Vietnam War, went into complete remission on their return to the U.S.A. This study highlighted the importance of social context in addiction and recovery. A number of researchers have proposed that acquiring a substitute behaviour that competes with the addiction, such as meeting new acquaintances or discovering new sources of hope and self esteem may play a major role in overcoming addiction (Vaillant, 1995; Miller, 1993; Brownwell et al, 1980).

The overall aim of the present study was to conduct qualitative research exploring the views of heroin users and their experiences with substitute drugs, specifically methadone and subutex, and substitute prescribing treatment agencies. The population for this study was recruited from a structured day care program that prescribed subutex to its clients. Smith (2001) supported the importance of qualitative research as he felt it enabled the capturing of emerging themes and concepts, as opposed to reducing individuals' thoughts and experiences to quantitative categories. Smith (2001) proposed a 'natural fit' between qualitative research and semi-structured interviews as the interviewer is able to delve further into any interesting avenues that surface, thus capturing the richness of the themes emerging from the respondents talk. Semi-structured interviews were also considered the most appropriate form of data collection due to the sensitive nature of some of the topic under discussion (Langley, 1994).

The interview material was analysed using a Grounded Theory approach (Glaser and Strauss, 1967). Grounded theory analysis consists of a constant comparative method with repeated movement between data and analysis (Strauss and Corbin, 1990). The inductive nature of this approach is unique in that it assumes an openness and flexibility of approach and allows a conceptual framework to emerge from the data (Charmaz, 2001).

This study was intended to explore and expand upon previous qualitative research conducted in the area of heroin users' views and experiences with substitute drugs, with attention being paid to methadone and subutex (Neale, 1998, 1999a, 1999b; Fischer et al, 2002; Koester et al, 1999). The heroin users' perspectives and experiences with treatment programs were also explored to expand upon the findings of Sell and Zador (2004) and Neale (1999a).

## **Method**

### **Participants**

The participants were recruited from a drug treatment service which provides an abstinence-based structured day care (community rehabilitation) program. The sample contained nine subjects, all of whom were recovering from heroin addiction. Seven of the subjects were male and two were female, which is representative of the gender differences within drug use in Britain. The subjects' ages ranged from 26 to 45, with a mean age of 32. For all of the subjects, their drug use had developed during their teenage years. The ages at which the subjects first took illegal substances ranged from 11 to 17, with a mean age of 14. The ages at which the subjects had first used heroin ranged from 17 to 30, with a mean age of 19.8. The duration for which the subjects had been actively-addicted to heroin ranged from 4 to 26 years, with a mean time period of 12.3 years.

The participants were all at various stages of their addiction/recovery process. At the time of the study, six of the subjects were currently in treatment receiving subutex and three had completed their subutex treatment program. Of those who had completed their treatment program, all were using the continued support and aftercare provided. Seven of the nine participants had previously received prescribed methadone.

All participants gave informed consent and were informed that all information would be kept anonymous and confidential.

### **Materials**

Participants were issued with a standardised consent form (Appendix 1). Each interview was based on a set of standardised semi-structured guidelines (Appendix 2). An Olympus voice and music DM-1 Dictaphone was used to record each interview. The interviews were then transcribed onto Microsoft Word (Appendix 3).

### **Procedure**

The study was set up in collaboration with a drug treatment agency that provided contacts and assisted with the organisation of the interviews. No incentive was

offered to the participants. Participants were assured of participant confidentiality and informed that they were under no obligation to answer any questions, and they could terminate the interview at any time. Subjects were encouraged to speak freely and to discuss their own thoughts and concerns; however, attempts were also made to address all of the key issues with the subjects. Prior to the interview, subjects read and signed the consent form.

A qualitative design using semi-structured interviews was adopted. The interviews considered the participants views and experiences with substitute prescribing, paying particular attention to methadone and subutex. The interviews lasted from 18 to 61 minutes and were later transcribed onto Microsoft Word. A Grounded theory approach was adopted to analyse the interviews (Glaser and Strauss, 1967; Strauss and Corbin, 1990), which allowed for the emergence of themes and sub-themes from the data itself rather than from the testing of pre-existing hypotheses.

## Results

A number of significant themes emerged from the Grounded theory analysis of the interview material. Each theme is made up of a series of sub-themes which emerged from within the overall theme. To avoid any ambiguity, the themes are presented separately and the sub-themes are presented in a table under each main theme. However, the themes are clearly interrelated, with some aspects of themes heavily dependent upon other themes.

The analysis focuses on the following five main themes which emerged from this study:

1. Reasons for obtaining a methadone prescription.
2. Experiences and views on methadone programs.
3. Views on methadone.
4. Views on subutex.
5. Views on ideal opiate treatment and successful recovery.

### **1. Reasons for obtaining a methadone prescription.**

The study found that the subjects had many and varied reasons for obtaining a prescription for methadone. Only those participants who had received a methadone prescription were considered in these findings (n=7). Table 1.1 states the twelve most commonly cited motivational factors for participants actively seeking a methadone prescription.

Table 1.1: Reasons stated for drug users seeking a methadone prescription.

Reason for obtaining prescription	Number of participants	Percentage of participants
To abstain from illegal drug use	7	100
To take the pressure off drug use	7	100
To reduce withdrawal symptoms	6	85.7
For a safety net	6	85.7
To regain control on life	6	85.7
For illegitimate use	6	85.7
To take a break from using	5	71.4
Deterioration of health	4	57.1
Hit rock bottom	4	57.1
Ordered into treatment	4	57.1
For reactive reasons	3	42.9
Prison sentences	3	42.9

*N.B. Participants expressed more than one reason for seeking a methadone prescription.*

Each participant stated that they had had more than one experience with a methadone program and it was not uncommon for individuals to mention between two and five main motivational factors. Every participant stated that they had sought treatment with the intention to **abstain from illegal drug use** on at least one occasion.

*“I wanted to get clean and sort me head out like” (2.9).<sup>1</sup>*

*“I didn’t know what I wanted other than I wanted to get clean. I needed to get clean and I still had a good chance at getting me life back together at that point cos it had only been a few years since me life had fallen apart” (8.2).*

Despite the obvious intentions of every participant to get clean through a methadone prescribing program, it was always the case that they did not succeed in remaining

<sup>1</sup> After each quotation, the first number within the bracket refers to the transcript number and the second number refers to the page in the transcript.



abstinent from illegal substances. Of the seven participants interviewed who had been prescribed methadone, none had overcome their heroin addiction through a methadone program. It was also evident that regardless of unsuccessful first attempts on methadone programs, a number of participants were willing to make several more attempts at using methadone programs.

*“I went back to the Doctor and asked for the methadone prescription back so that I could stop using heroin” (7.1).*

Figure 1.1 shows the participants’ reasons for obtaining their first methadone script in comparison to their reasons for obtaining future scripts following an unsuccessful first attempt. As can be seen, the majority of the participants sought their first methadone script with the intention of using it to abstain from future drug use (71.4%). However, only 14.3% sought a methadone prescription at a later date as a means to stop their heroin use. It can also be noted that only 14.3% of participants initially wanted a methadone prescription to abuse whereas 71.4% actively sought a methadone prescription for illegitimate use after their initial experience with a methadone program.

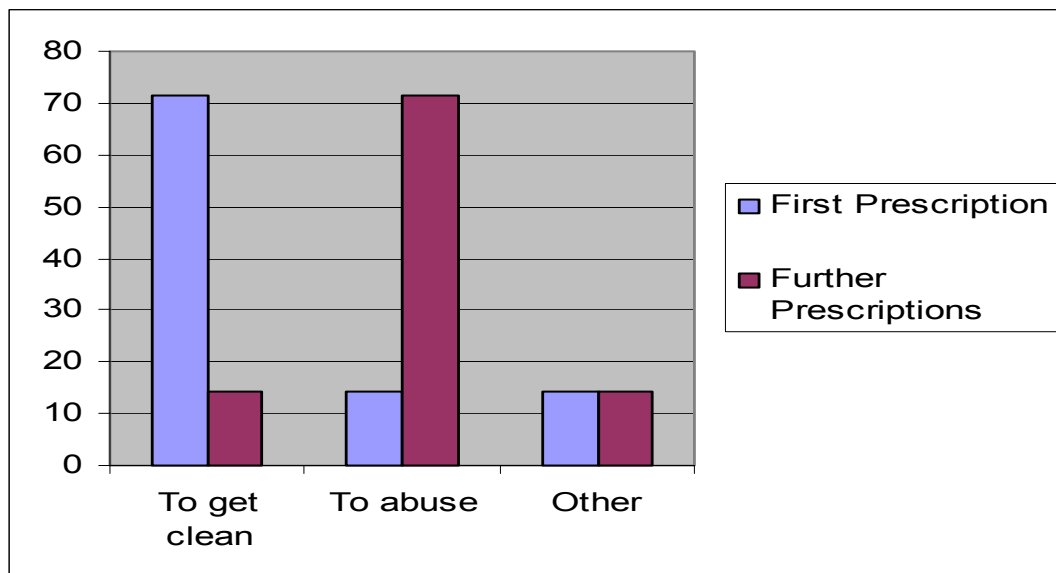


Figure 1.1: Percentages of participants stating reason for seeking treatment on first prescription and further prescriptions.

Evidently, following unsuccessful attempts of using methadone to abstain from using heroin, clients' reasons for obtaining future prescriptions were changed. All clients stated that on obtaining further prescriptions they wanted methadone to **reduce the pressure** put on them by their heroin addiction.

*"I just needed to take the pressure off for a bit. Easy option" (5.6).*

*"You know when you wake up in the morning you have your methadone don't you, so you don't have to go out and get some gear" (1.3).*

A number of participants also stated that when they felt that their drug use had escalate to a level where they were unable to cope then they were motivated to obtain a methadone prescription to **take a break**. In all cases, participants stated that their intentions were to return to using heroin at a later date, and many even set a time for which they would resume using heroin.

*"It's just like a little holiday from it. A little holiday from the gear" (8.3).*

*"I remember my general attitude at the time was I'll have a couple of months break you know, then I'll go back into it" (5.6).*

A number of participants also stated that a methadone prescription acted as a **safety net** for times when they had no heroin available. By having methadone available, the subjects felt more secure psychologically as they knew that they could alleviate their withdrawal symptoms if there was no heroin available.

*"Everyone that I've met all over the country methadone is there for a safety net" (2.2).*

*"It's like fear of withdrawing" (2.4).*

Another frequently cited motivational reason for acquiring a methadone prescription was in an attempt **to reduce or eliminate the withdrawal symptoms** caused by coming off heroin or when there was insufficient heroin available. Again, many of the participants did not intend to stop taking heroin on a permanent basis at this stage, but would use the methadone so as to be able to ease the withdrawals and thus be able to actively seek heroin.

*"I knew that it just stopped you withdrawing and basically I just wanted that"* (6.1).

*"It just took the pain away for a couple of hours...every time we used to rattle we'd just use it"* (4.3).

Another prominent reason for seeking treatment was the feeling of **losing a sense of control** over ones' life due to the addiction. Many of the subjects stated that their addiction to heroin had taken over their lives as they were constantly preoccupied with where they would obtain money for drugs and also the search for drugs. By obtaining a methadone prescription, the subjects were able to regain some control over their lives as they had the means to prevent their withdrawal symptoms.

*"I felt like a prisoner. Nothing could alleviate that feeling"* (2.9).

*"Obviously I didn't want to have that inconvenience in my life. I didn't want to be dependent on drugs"* (5.2).

Participants stated that another key motivation for obtaining a methadone prescription was substantial **deteriorations in their health and mental state**. *"Looking like I'm nearly dead. Really skinny and gaunt, looking like I'm nearly dead"* (1.5).

*"My health had really deteriorated and my mental state had really really deteriorated"* (5.5).

In relation to deterioration of mental state, nearly half of participants cited reaching **rock bottom** as playing a major role in encouraging them to seek treatment. Each individuals rock bottom experience varied greatly and was very personal, but did encourage the subject to seek treatment

*"I hit my own personal rock bottom which I think is something you have to do to seriously want to come off"* (7.7).

*"Looking back I had reached the end"* (2.9).

Participants had also obtained methadone prescriptions at the suggestion of others, for example a doctor or a friend, or **in order to please others**, in particular family members.

*“It was stating to effect my work...it was affecting my family relationships that was the main reason for sorting it out” (5.1).*

*“With me having two small children I really thought that it was time that I got my act together. See the intention was there cos I knew that I couldn’t pursue that lifestyle for much longer because I was going to loose my children” (7.3).*

For others, treatment was sought due to **orders from prison or drug services**. Interestingly, in this study it does not appear to affect the outcome of treatment if the participant was ordered into treatment in comparison to deciding to enter treatment for themselves. However, this may be due to the fact that none of the participants were able to overcome their addictions through a methadone program.

*“Then I got out and my HTCC said to come here” (5.8).*

*“She said we’ll put you on a maintenance script...but they would only do that if I agreed to come here. So, basically at the time I had no choice but to do it” (6.5).*

**Prison sentences** were also said to play a major function in motivating individuals to seek treatment for their drug addictions.

*“Two prison sentences later I realised that it was about time I sorted myself out” (5.10).*

The prospect of having to spend time in prison due to illegal activities to fund their drug addiction was also cited as a motivational factor for seeking treatment. Of those who had spent time in prison, all had to go through their withdrawal symptoms from heroin without any substitute drugs. This factor, in many cases, deterred the individual from placing themselves in that situation again as the experience had been so horrific.

*“I’d run out of gear like and you haven’t got any family or an income so you’re going to end up thieving and then you’re going to get caught aren’t you. And then you’ll have to do your rattle in jail.” (4.4).*

**Illegitimate reasons** were also a key motive for obtaining a methadone prescription, especially in later experiences with methadone programmes. Participants stated that by having a methadone prescription the financial pressure of constantly having to obtain drugs was reduced.

*“If you have it you don’t after go raise money for gear....and then once you’re feeling better you go and get some money and then some gear” (1.1).*

Others used their methadone prescriptions to sell so that they could then buy heroin. One participant, who had never been prescribed methadone, talked about how he saw those around him abusing methadone. He classed this as a reason for not getting a methadone prescription himself.

*“Everyone who I know who was on meth would use it to sell for gear or would use it when there was no gear there” (4.3).*

*“Or I’d sell a bit of it, you know what I mean” (6.2).*

Participants also stated that they obtained methadone prescriptions as a source of free drugs, which they would then use when there was no heroin available to them.

*“It was just free drugs, that’s the way I looked at it” (6.1).*

*“I would double up. I would have 60 to 70mls purely for the effect....it was purely there for me to abuse, you know” (7.2).*

## **2. Experiences and views on methadone treatment programs**

None of the participants in this study had had successful attempts at abstaining from illicit drugs through the use of methadone programs, although some had achieved personal goals that they had set at the time, for example to take a break from using heroin. Only those participants who had received a methadone prescription and had gone through a methadone program were considered in these findings (n=7). Every

subject in this study used illicit substances on top of their methadone prescription at some point throughout their treatment, and in most cases their use of illicit drugs was soon after entering treatment and was for a prolonged period.

Table 2.1 demonstrates the main views that participants gave on their experiences with methadone treatment programs. Each of the participants expressed a number of varying views on their experiences with methadone programs.

Table 2.1: Percentage and number of participants expressing a view on their experiences with methadone treatment programs.

<b>Experience with methadone program</b>	<b>Number of participants</b>	<b>Percentage of participants</b>
Inadequate counselling	7	100
Long waiting lists	6	85.7
Lack of staff understanding	6	85.7
Doctors take patients word for their heroin use	5	71.4
Treatments too generalised	5	71.4
Effects of methadone not explained	5	71.4
Lack of treatment options available	5	71.4
Failed attempts heightened addiction	5	71.4
Stigma of addiction	5	71.4
Inadequate drug screenings	4	57.1
Ease of obtaining methadone	4	57.1
Doctors too willing to increase dose	4	57.1
No education of addiction	4	57.1
Not discouraged from using other illegal substances	4	57.1

*N.B. Participants stated more than one view on their experiences with methadone programs.*

In general, the participants' views on methadone prescribing were negative, and a number of key areas were highlighted as in need of improvement. Every participant stated, on several occasions, that they had received **inadequate support and counselling**. The most commonly cited shortcoming was an overall lack of available support, with many participants only being offered a 20-30 minute weekly/fortnightly counselling session during their time in methadone programs.

*"They had a counsellor who came up once a month and I could see her for five minutes which is no use to no one" (5.2).*

*"I think I needed basically counselling...and you don't get any of that at IDAS [local treatment agency] or any of the other places, you just get a script and that's it"(6.6).*

Any counselling that was received was generally viewed as being inadequate. The most commonly cited complaints were a lack of one-to-one counselling as well as counsellors not broaching the issues that were most important to the clients.

*"No counselling as such, no one-on-one which is what you need. There was only group" (2.7).*

*"...they weren't really looking for reasons why. It was just about my health and things like that" (5.7).*

One aspect of methadone programs that the majority of the participants expressed particularly strong negative opinions about was the **long waiting lists** to receive treatment. There was also a large discrepancy between the waiting lists for different services with the waiting lists for clients varying from immediate help to having to wait six months to receive any type of treatment.

*"You have to wait ages. About 12 weeks or something before you even have a chance of getting help"(8.3).*

*"When I first went for a methadone script it took about 6 months I'd say to get me first script"(1.1).*

The participants all stated that the long waiting lists had a detrimental effect on their heroin use as well as their physical and mental well-being. Many of the subjects stated that when they were prepared, in themselves, to enter treatment, they needed the help immediately. Delays resulted in them losing the motivation to stop using illicit drugs.

*“Once you get to the point where you want to do something about it, by the time you really get any constructive help then you’ve lost the impetus to do something about it anyway. You’re that fed up of waiting” (5.1).*

*“When you’ve hit that point and you’re desperate and you want to stop...when you have to wait obviously it’s a downer cos you’ve made that choice. You’re using gets worse cos you can’t cope.”(9.1).*

A large proportion of the participants also stated that methadone programs often have **inadequate or infrequent drug screening services**. The most commonly expressed view was that the lack of drug screenings enabled clients to use illegal substances on certain days of the week when it was known that there were no imminent screenings.

*“It was just a case of they would screen you once a week, they would put you on a methadone script and then send you away” (5.2).*

*“...they don’t screen you often enough so you can get away with it. As soon as you know in your head that you can get away with it it’s all over”(9.1).*

A large number of participants felt that the actual **prescribing of methadone lacked proper controls**, and thus was too readily available for individuals who were not ready for methadone treatment. The participants who felt that methadone was too readily available had all received methadone through their GPs as opposed to a specialised drug service. Participants expressed that doctors were too willing to prescribe methadone without any other support systems being available to the client, which in most cases would have been as vital as the substitute drug itself.

*“Well, I went to me G.P like and I were 17 then. He gave me a methadone script straight away like...like a 17 year old you know what I mean”(6.1).*



*“Even when I’d messed up a couple of times and went back to the same doctor he’d put me back on the same script again. He’d say you’ll feel stronger this time, but it’s not about strength. It’s a case of dealing with things.”(8.3)*

Doctors would also **decide upon a client’s methadone dose by taking their word** for the amount of heroin they were using. However, as many active users will admit, “we always want more”, and thus many participants admitted to exaggerating their heroin use so as to be prescribed a higher methadone dose, thus allowing them to abuse their prescriptions.

*“Q. How did the doctor decide your dose?”*

*P. On how many bags I was using. I told them higher...to be honest I don’t know any addict that tells the truth when it comes to medication” (9.2).*

Participants also stated that the doctors were often **too willing to increase their methadone prescriptions and/or prescribe other drugs** such as benzodiazepanes. Subjects stated that the prescribing regulations were too relaxed which enabled them to abuse a number of prescription drugs, thus worsening their drug addiction.

*“However much I wanted, well within reason, like he wouldn’t give me 25 pints a day, but however much I wanted I could have that for the rest of my life, no problem”(2.5).*

*“I asked for diazepam again to help me sleep, they just gave me anything I asked for. You know I’m a drug addict. I’ll abuse a drug if I can do, if the opportunity is there then I’ll take it” (5.6).*

Participants also said that in most of their experiences their cases had not been looked at individually, and they felt that their **treatments were too generalised** and did not cater for each client’s specific needs.

*“For me, it wasn’t very well managed. My case wasn’t looked at individually” (5.10).*

*“It wasn’t like take on an individual case then” (2.3).*

More than half of participants also felt that they were **not offered any education** about their addiction. Their experiences with methadone programs were more concentrated on detoxification off the heroin rather than rehabilitation and dealing with the addiction as a whole. The majority of the subjects felt very strongly about the need for rehabilitation and education about their drug addiction, and many felt that it was due to the lack of rehabilitation that they did not complete their methadone treatment.

*“I didn’t know anything about maintenance programs. The addiction hadn’t been dealt with” (2.5).*

*“I didn’t know that any mind altering drug will lead you into the drug of your choice” (2.14).*

A number of participants also felt that the **effects of methadone were not adequately explained** to them and that methadone use was encouraged as a substitute drug for heroin.

*“I wasn’t told anything. I didn’t really understand it at the time, you know what I mean. I was only a young lad like so I just used it to get mashed on like” (6.2).*

*“I was totally uneducated. I’d only been on it for a short while so I was like yeah this is a cure you know. This is going to be great...that was the first time that my hopes were shattered” (8.3).*

Participants also felt that methadone **programs did not discourage against using any illegal substances other than heroin**. Clients were left with the understanding that they were free to use other illegal substances. However, in all of the participants’ experiences, this lead them back to heroin use.

*“It was a full screen, they knew everything that was in my system, cannabis cocaine, they were just like as long as you’re not taking heroin” (5.3).*

*“I would be able to come out of there and have a drink and have the odd joint but it wouldn’t be the odd joint I’d be smoking. As long as I wasn’t using heroin, that’s what they made us believe. We weren’t educated” (2.6).*

Participants also expressed negative feelings regarding the **lack of treatment options available** to them. In many cases, it was felt that methadone was the only substitute drug available to them and methadone was often promoted as the best substitute drug available.

*“There didn’t seem to be very many options. It was the easiest option.”(5.2).*

*“I got methadone there, but I didn’t really want to have methadone like, but back then subutex was pretty new” (6.3).*

All of the negative factors regarding the clients experiences with methadone programs contributed to unsuccessful attempts at overcoming their heroin addiction. Every participant stated that those **failed attempts resulted in a heightened heroin addiction** and an increase in negative feeling towards methadone as a substitute drug.

*“...my heroin use got a lot worse. I used more like...it didn’t help me at all like” (6.3).*

*“...it made me habit bigger. Made me more resentful...it was like cos I didn’t have the methadone I couldn’t just take the normal amount of heroin cos I was rattling off the methadone as well so I had to take double”(9.3).*

*“Whenever you relapse it’s worse like it don’t get any better...it gets worse cos you know that you’ve done well and then shit it all up again” (6.5).*

The doctors and the staffs’ attitudes towards the clients on the methadone programs also contributed to the participants’ negative views of methadone programs. The majority of participants stated that the **stigma of heroin addiction** was evident in the workers’ views of the clients and many felt that this hindered their progress.

*“There’s a lot of stigma attached to substance abuse...I hated going into the doctors’ surgery. You know just that way that the staff looked at you, it really was a horrific experience” (5.5).*

*“You really feel that you’re not worth their time. That’s the way they make you feel about it” (8.3).*

*“It was humiliating though going to the chemist and them having to watch you drink it and there would be other customers in the shop” (9.2).*

It was clear from the interviews that participants felt very strongly about the **lack of understanding** that the staff they encountered expressed about their battles with addiction. This was felt to seriously undermine the effectiveness of the services being offered.

*“My main criticism is that there’s no compassion. They don’t care.” (2.6).*

*“...the general attitude is you made your bed, now go lie in it” (5.5).*

### **3. Views on methadone**

Based on personal experiences with methadone, along with observations of others using methadone, every participant strongly believed that methadone is an extremely poor substitute drug for heroin. Overwhelmingly, the participants’ views on methadone were negative, although a small number of participants did recognise that methadone could have potential as a substitute drug.

Table 1 shows the negative views expressed on methadone as a substitute drug. All participants were included in the calculations regardless of whether they had ever entered a methadone treatment program or not, as their views on methadone were what was of interest. As can be seen, the subjects expressed multiple opinions on the negative aspects of methadone as a substitute drug.

Table 3.1: Percentage and number of participants expressing negative views on methadone as a substitute drug.

View on methadone	Number of participants	Percentage of participants
Can use illicit substances on top	9	100
More addictive than heroin	9	100
Negative psychological effects	7	77.8
Controls life	7	77.8
Too easily abused	6	66.7
Length of time for methadone treatment	6	66.7
Chose heroin over methadone	5	55.6
Swapping addictions	5	55.6

*N.B. Participants expressed more than one negative aspect of methadone.*

The most commonly expressed negative aspect was that it **did not prevent individuals from using illegal substances** whilst on methadone. All subjects stated that this was a major drawback of methadone as a substitute drug, as it provided no prevention from them returning to illicit drugs.

*“...basically with methadone, it lets you still use” (5.10).*

*“I was just taking that and still using on top like cos there’s nothing stopping you with methadone” (6.1).*

*“I don’t know anyone who’s on meth straight without using anything else like” (4.3).*

The individuals in this study showed strong evidence of initially obtaining methadone with the intention of not using illegal substances on top. However, none of the participants used methadone without also using illicit substances. One participant abstained for six months, but for the majority, illicit drugs were used within the first couple of weeks of entering the methadone treatment program.

*“For the first six months I did really well and didn’t use and then after that I learnt how to use heroin and methadone and then that started. It was just so easy” (9.1).*

*“I did use it properly for like a couple of weeks but then after that I’d use on top” (1.2).*

The general view on the effectiveness of methadone as a substitute drug was that it was **too easily abused** and that it rarely worked for anyone.

*“I think that it has no place in treatment. It’s a waste of time. It creates more problems” (5.10).*

*“It’s too easy on methadone. It’s too easy to use, it’s too easy to save up and have double” (9.6).*

*“But methadone, I can’t see any way that that helps you” (6.6).*

The main reason that participants cited for using heroin and/or other illegal substances whilst on methadone was that **methadone just was not enough** to quench their desire for drugs.

*“But it doesn’t stop you wanting gear, you know what I mean” (1.2).*

*“...with the methadone you get the sensation of it but you don’t get the warmth. You don’t get the entire feelings so it’s not long before you’re chasing the rest of it” (9.6).*

Every participant in this study also had very negative views regarding the addictiveness of methadone and all felt that it had **more addictive properties than heroin**. All of the subjects felt particularly strongly about this point, as nearly all of them had had horrendous experiences in withdrawal from methadone.

*“...it’s far more addictive than heroin and it’s very difficult in the long run if you try and stop” (5.6).*

*“Some people have been on meth for twenty years and then when they want to come off it they are so dependent on it” (4.5).*

Participants felt extremely strongly regarding the difficulty of withdrawing off methadone, and each participant stated that it was harder to withdraw from methadone than it was to withdraw from heroin.

*“It’s far more difficult to withdraw from. It gives you false hope” (5.11).*

*“The withdrawal from the methadone was absolutely unbelievable. I have done withdrawals from heroin but the methadone was just. Indescribable really.” (7.4).*

In particular, the participants found the physical aspects of the withdrawal from methadone extremely difficult to deal with and also the length of time that the withdrawals continued for.

*“Couldn’t get no sleep. Seemed to be your bones are more achy they seem to ache a lot more. Basically, it’s the same as heroin just about ten times worse” (6.2).*

*“When you come off it it soaks into your bones and everything and you really do rattle. It’s horrible” (3.6).*

The negative effects of methadone were often so extreme that the participants would **choose to return to using heroin** rather than continue using methadone.

*“...they chose to use the heroin rather than get a script from the Doctors because they’ve learnt the hard way like” (2.12).*

*“...the rattle was so bad....that I never wanted to touch the stuff again. I never took it again.”(8.5).*

Participants also stated **the length of time that it takes to come off methadone** as a negative aspect of its use as a substitute drug. In some cases, this factor dissuaded individuals from using methadone to abstain from heroin.

*“I’ve seen people take 18 months to get off meth so I never really had any intention of using it to get clean. I just wanted a break” (5.6).*

*“...it takes too long to get out of your system” (3.6).*

Another negative view expressed by the majority of participants was that using methadone only resulted in **swapping addictions** from heroin to methadone. This caused apprehension with the participants as their experiences had taught them that methadone is so highly addictive and difficult to come off.

*“I tried to get off it (heroin) with IDAS [local treatment agency] and that but all they would offer me was methadone and I was like what’s the point cos I just want to get off it all together. You know what I mean. That’s just swapping addictions” (4.2).*

Participants also very commonly expressed their views on the negative **psychological effects** of being on methadone. Participants were most concerned with the low moods and the general fear of being without methadone.

*“The low moods...the feeling down and your head all over the place” (2.12).*

*“A lot of it was psychological as well, like you know I didn’t want to be without it like” (7.4).*

Three quarters of the participants stated that methadone does **nothing to help with the psychological aspects** of recovering from heroin addiction. The reappearance of feelings and psychological issues that are suppressed by the use of drugs was often expressed as a factor that lead to an unsuccessful attempt at recovery.

*“...methadone it gets rid of the physical symptoms but it doesn’t get rid of the psychological symptoms and that needs counselling and things like that” (8.3).*

*“... it’s stopping the physical withdrawals which is about 30% of the battle. But the feelings that you’ve got. It just doesn’t help with anything else. You just loose hope and slowly give up” (8.4).*



Methadone was also negatively viewed in the sense that it took almost complete **control of the individual's life**. The most common complaint was a feeling of a lack of freedom due to the rigidity surrounding the collection of methadone.

*"...the way you run your life around it...there was a lot of control in my life"* (7.6).

*"...it's about the control. I mean I couldn't go anywhere. I had to be somewhere at a specific time to get my script...It was total control. Total control of my life"* (2.15).

Although the subjects' views on methadone as a substitute drug were predominantly negative, a small number of participants did convey that methadone had some benefits provided it was not abused. Table 3.2 illustrates the subjects' positive views on methadone, with all participants' views being taken into consideration. However, it should be noted that those who had not themselves been prescribed methadone (n=2) were more likely to express that methadone could play a role in treatment for some individuals.

Table 3.2: Percentage and number of participants expressing positive views of methadone as a substitute drug.

<b>Views on methadone</b>	<b>Number of participants</b>	<b>Percentage of participants</b>
Eliminates withdrawal symptoms	6	66.7
Provides periods of abstinence	4	44.5
Could play a part in treatment	4	44.5
Helps to regain control on life	3	33.4

*N.B. Participants expressed more than one view on the positive aspects of methadone.*

The most commonly stated positive feature of methadone was its ability to **reduce or eliminate the physical aspects of withdrawal** from heroin. A high proportion of

subjects did state that methadone was successful in alleviating the physical symptoms of heroin withdrawal. However, it must be remembered that methadone was not a successful substitute drug for any of the participants.

*“You don’t have to go through any of the withdrawals” (9.3).*

*“...stops your craves, stops you clucking basically” (1.1).*

The use of methadone often resulted in the participants having **initial periods of abstinence from illicit drugs**, which varied from two weeks to six months. In a small number of cases, this was sufficient in the individual achieving their personal goal from treatment at that time, such as to take a break from using heroin.

*“It felt good at first cos I wasn’t using and that’s what I wanted” (9.2).*

*“I did use it properly for like a couple of weeks but then after that I’d use on top” (1.2).*

A small number of participants also noted that methadone can enable you to **regain control over your life**, although these were often the participants who had had periods of abstinence due to methadone for more than six weeks.

*“When I’ve used methadone I’ve sort of got me life back on track like 50%, like it helps to get to work and everything” (6.7).*

*“It gives you the stability to try and put your life back together” (8.9).*

Approximately half of the participants thought that methadone **could play a positive role in treatment** for heroin addiction providing that the program was not abused. Three out of four of the participants who believed that methadone could work if used properly had known of at least one person for whom methadone had successfully lead them to recovery. The two subjects who had not gone through a methadone treatment program themselves expressed views that methadone could work for some individuals. However, they themselves had not wanted to use it as a substitute drug.

*“I know people who have come off gear at IDAS [local treatment agency]...It can help but it just depends how you are mentally” (6.6).*

*“I guess its individual and that it helps some people” (4.2).*

#### 4. Views on subutex

All of the participants in this study were currently on a subutex prescription, or had recovered from their opiate addiction on a treatment program which used subutex. Some participants had had prior attempts at recovery using subutex at different drug treatment agencies across the country. However, none of the attempts had been successful. Table 4.1 shows the percentage of participants expressing a positive or negative view on subutex as a substitute drug. As can be seen, the participants were extremely positive about subutex, and there were very few negative aspects of the drug mentioned. The negative aspects were also less frequently cited in comparison to the positive aspects of subutex.

Table 4.1: Percentage and number of participants expressing particular views on subutex as a substitute drug.

<b>View on subutex</b>	<b>Number of participants</b>	<b>Percentage of participants</b>
Optimum substitute drug	9	100
Promotes abstinence	9	100
Superior to methadone	7	77.8
Eliminates withdrawal symptoms	7	77.8
Improves all aspects of life	7	77.8
Quick speed of treatment	5	55.6
Difficult to handle at low doses	5	55.6
Potential for abuse	5	55.6

*N.B. Participants expressed more than one view on subutex as a substitute drug.*

All participants regarded subutex as a very positive step forward in the treatment for heroin addiction, and most referred to it as the **optimum substitute drug**, and expressed that it was the only substitute drug available that would work for them.

*“Everyone that I’ve spoken to thinks that subutex is a wonder drug” (1.6).*

*“Subutex for detoxing is the miracle pill, that is the business” (2.7).*

*"I thought subutex was a miracle drug first time. Brilliant. Everything I was looking for" (8.1).*

When compared to methadone, all participants felt that subutex was by far a **superior substitute drug to methadone**, and all felt that methadone should no longer play a role in the treatment for opiate addiction now that subutex was available.

*"They should scrap it (methadone), now that subutex is out people ought to go onto subutex not meth" (1.6).*

*"If you really and truly want to stop taking heroin, then it's a much better alternative to methadone" (7.6).*

The main beneficial feature of subutex expressed by the subjects was the fact that illegal substances could not be used, thus **abstinence** was promoted. All participants felt that abstinence was essential for them to overcome their addiction, and many felt that their lack of abstinence had played a large role in their previous failed attempts at recovery.

*"With subutex, there's not so much of the instinct to use cos you know you can't" (9.6).*

*"It had that blocker effect and I did try a little bit of heroin but there was nothing, no real effect so therefore heroin lost it's appeal"(8.6).*

A number of participants felt that a further positive feature of subutex was the **speed in which recovery can take place**. A large proportion of the participants had expressed that methadone treatment programs were too long, thus individuals lost the desire to get clean. However, the length of subutex treatments was expressed as meeting the subjects' needs far more than methadone programs.

*"The speed in which subutex can be used is phenomenal because as soon as you get your body away from dependency, the sooner you can start dealing with the issues that lead you to addiction"(5.10).*

One participant had stretched her subutex treatment over an extended period of time and had found that when she finally did wean herself off she was not surrounded by a sufficient support network, and thus relapsed. On her second attempt on subutex, she had decided to do the treatment in the recommended time period, and found subutex to work much better for her.

*“I’ve coped a lot better cos I want to do it quick cos this time it’s me choice like and I can see where I went wrong last time”(9.5).*

All of the participants felt that subutex was very effective in **reducing or eliminating their withdrawal symptoms** from heroin. Obviously, this is a very important aspect of recovery, and whilst on subutex participants felt that, in particular, they lost their cravings for heroin.

*“...subutex stops your cravings and that. I ain’t joking with you when I say this like but when you’re on subutex it’s like you were never on the gear, you don’t even think about it”(6.4).*

*“Without it I couldn’t have done it. It stops the cravings and all like, the physical symptoms of coming off it” (3.4).*

Overall the participants expressed that subutex had a very **positive impact on all areas of their lives**. Most importantly, subutex was said to improve the physical and psychological health of the subjects, which led them to improved family relations and the ability to stabilise their lives.

*“So my life’s all changed like putting weight on, having money in my pockets to do what I wanna do”(1.6).*

*“Subutex can help cos it gives you that bit of time to get your head right, to get to thinking how you should be thinking” (6.6).*

Although, in general, the participants’ views on subutex were extremely positive, a small number of participants did experience **difficulty handling subutex at lower doses**. In particular, it was stated that when subjects reached low doses of subutex the cravings returned, at which point some participants had previously relapsed.

Some participants also stated that they had previously had relapses immediately after completing their subutex course.

*“When I get down to certain levels of subutex...the blocker goes as well so the cravings come back”(1.4).*

*“I’ve been all right being weaned off them like but as soon as I’ve come off them like I’ve relapsed”(6.4).*

A small number of the subjects did acknowledge that subutex does have some **potential for abuse**. One participant stated that they had used subutex on the days when they had no money to obtain illegal drugs, whilst another participant stated that he had sold subutex for illegal substances.

*“...there’s people out there like on the street who want to buy, it you know what I mean” (1.6).*

*“For months and months I continued to get my subutex tablets. Used it on the weekends which is when I had no money and then as soon as Monday came I’d be using again. Other people wanted to buy my subutex so I would sell it” (7.6).*

## **5. Views on an ideal opioid treatment and a successful recovery.**

All the participants in this study expressed very strong views regarding their ideal opiate treatment program despite there being no direct questioning regarding this issue. Table 5.1 shows the percentage of participants expressing particular views on their ideal opiate treatment program.

Table 5.1: Percentage and number of participants citing aspect for ideal aspect of opiate treatment

<b>Aspect of ideal opiate treatment program</b>	<b>Number of participants</b>	<b>Percentage of participants</b>
Sufficient counselling	9	100
Making life style changes	9	100
Learning coping mechanisms	9	100

Learning from past experiences	8	88.9
Abstinence based treatment programs	8	88.9
One-to-one counselling	7	77.8
Reaching rock bottom	7	77.8
Counsellors who have experienced active addiction	6	66.7
Group therapy	6	66.7
Dealing with the root of addiction	6	66.7
Being ready for treatment	6	66.7
Wanting to abstain from illicit drug use	6	66.7
Individualised treatment programs	5	55.6
Prison sentences	4	100*

*\*100% of the participants who had spent time in prison (n=4) felt that it was the ideal time to target detoxification and rehabilitation.*

*N.B. Participants expressed more than one idea for their ideal opiate treatment program.*

Each participant mentioned, on a number of occasions, the importance of **adequate counselling** being available whilst trying to overcome heroin addiction.

*That's why I never finished at IDAS cos there's no support there, there's no counselling. You're on your own basically" (6.6).*

*"The support is good for you, you know what I mean, like if you're craving then you can talk to someone like...You can't do it on your own, you just can't" (1.6).*

Participants also expressed the importance of the availability of **one-on-one counselling** for those times when the participants felt unable to manage without using illegal substances.

*“I came in here and had a one-to-one with one of the therapists...it made it easier” (2.11).*

*“Counselling is like where you are going wrong in life and all sorts. It’s like the counsellors here if you have any problems then you can just go to them and talk through them and they listen to you. I’ve had a few one-to-ones in here” (3.6).*

Participants particularly stressed that speaking to **counsellors who had themselves experienced active addiction** was much more beneficial than speaking to counsellors who had no personal experience of addiction.

*“I personally find it very difficult to talk to someone about how I’m feeling when they have no idea where I’m coming from. Whereas the BAC, virtually everyone that works here has at some point in their life been in active addiction. That makes a massive difference because it’s far easier to take criticism and advice from someone who knows what you are on about and has been there” (5.8).*

*“That’s why this place is so great, every single person here is an ex-user and that’s what you need” (8.8).*

Participants also stated that having **group therapy** treatment sessions with others who are trying to overcome addiction can also aid recovery. In particular, it was stated that individuals can learn from others’ experiences of recovery and it results in the participants not feeling so isolated throughout their recovery.

*“...it’s sort of about hearing other peoples stories and having something to relate to...it kind of takes a while to realise that if they can do it, then surely I can too” (5.9).*

*“You’re in a room full of people who are doing the same thing and you have counsellors and that. its good here” (6.6).*

All participants stated that the biggest battle of overcoming heroin addiction is not the initial detoxification from the heroin, but the difficulty of remaining abstinent from the



drug. For this reason, counselling and education were deemed as extremely important and beneficial, especially during the first few months of recovery.

*“...it’s not as simple as just getting off it. It leaves you with all sorts of problems that you need help with” (8.3).*

*“Getting off is the easy bit, it’s the staying off that’s difficult” (9.5).*

However, despite the emphasis being put on the importance of counselling, most participants did state that counselling alone is not enough to overcome addiction and thus substitute drugs are needed.

*“They don’t prescribe anything what so ever, they are just there to talk. I thought that they were an absolute waste of space. You can do all the talking in the world but you’re a heroin addict at the end of the day and you need help to get off the heroin”(8.1).*

Participants placed particular emphasis on the importance of **dealing with the root of the addiction** in order to successfully recover from heroin addiction. Every participant said that unless you are able to deal with the real issues that each individual faces, then the addiction can not be dealt with and recovery will not be achieved.

*“...it’s a bit daunting at first cos you have to delve into yourself and face things that you’ve buried for a very long time...I’m only half way through but you have to do it to be able to recover, to get through it”(7.8).*

*“Drug abuse is just a symptom of the behaviour. If you can’t look at the behaviour then you’re just wasting your time no matter how much medical help you receive”(5.4).*

*“I was a complete mess cos I wasn’t sorting out the real root of the problem...and that’s what its all about” (7.5).*

An important factor that emerged in this study was that to successfully recover from heroin addiction, the individual **needs to be ready** to do so. With hindsight, participants were able to realise that previously failed attempts at recovery often

occurred when the individual was not completely ready to give up heroin and the lifestyle associated with drug use.

*“I wanted to give up but I probably hadn’t been ready looking back at it mind you” (6.5).*

*“I think that you have to be ready. Cos if you’re not ready then you won’t do it” (3.4).*

*“I knew that I had a problem a long time ago, but the fact was that I wasn’t prepared to deal with it. I didn’t want to deal with it” (5.9).*

One factor that every participant stated played an important role in their realisation that they were ready for treatment was reaching their own personal **rock bottom**. Each individual’s rock bottom experiences had specific relevance to their life experiences and varied from the possibility of losing ones’ children to the effect of a prison sentence.

*“Hitting rock bottom is a real important point. If it hasn’t got as bad as it can get then you can’t start climbing back out” (5.9).*

*“I hit my own personal rock bottom which I think is something you have to do to seriously want to come off” (7.7).*

Participants also noted the importance of **wanting to abstain from illicit substances** for themselves as opposed to seeking treatment for the sake of someone else such as a family member or doctor.

*“I just don’t think that I wanted it enough for myself. I was looking outside myself at things that should make me want to get off instead of looking inside myself” (8.2).*

*“...then I realised at the end of last year that I needed out, it wasn’t good for me any more. Literally, I couldn’t handle it any more. I was going crazy” (2.9).*

To successfully recover from heroin addiction, participants expressed the importance of **making lifestyle changes**. Participants noted that several of their failed previous

attempts at treatment had been related to their unsuccessful attempts at making life style changes. At the time of the interviews, all subjects were making concerted efforts to remove themselves from their drug taking lifestyles.

*“You just feel really lost cos obviously you’re still seeing the same people cos you can’t dramatically change your lifestyle cos you don’t know how to” (9.2).*

*“So the intention was there and it lasted a few weeks but the lifestyle hadn’t changed...so I had no choice really” (7.5).*

It was also regularly stated that it was vital to learn adequate **coping mechanisms** for times when the participants felt the temptation to use illegal drugs. A number of participants stated that group counselling sessions played a large role in helping to acquire the necessary coping mechanisms and behavioural changes.

*“It’s not just about dealing with withdrawals, that’s just such a tiny tiny part. The main part is learning to manage the skills and coping mechanisms to deal with being an addict, cos you’re never going to change that”(5.9).*

*“I choose not to go to places where there’s alcohol obviously...I’ve learnt to cope with it” (2.11).*

Participants also stated that they had **learnt from their past experiences** of substitute prescribing, and many felt that it was necessary to have several attempts at recovery before they were willing to put their complete time and effort into overcoming their addiction.

*“They say that you learn from your relapse and I did learn from that relapse” (2.9).*

*“This last relapse, I think I needed to do it cos it gave me a kick up the ass like” (6.5).*

All of the participants felt very strongly in favour of **abstinence-based treatment** programs, with all expressing that abstinence was the only way that they could see themselves overcoming their addictions. All of the participants felt that they were not

able to use any drugs in moderation; hence abstinence-based programs were the only treatment root that would work for them.

*“Well, it’s the only way really. Cos as we’re addicts it doesn’t matter what we have really cos we won’t do anything in moderation...I think it’s the only way for us” (7.7).*

*“Any mind altering chemical will take an addict back to the drug of their choice” (2.6).*

Participants also stated **that treatment programs should be more flexible and able to cater to the individual needs** of each client rather than providing generalised treatment plans. However, most subjects agreed that daily drug screenings would be beneficial if made mandatory as it would reduce the temptation of the clients to use illegal substances as they would no longer be able to use without it being detected in their systems.

*“Like you get screened like nearly every other day which is good” (1.6).*

Four of the participants in this study had been sentenced to time in prison, often for drug related reasons. Each of the subjects felt that **prison** was an ideal place to go through detoxification as they were left with no other alternatives.

*“The thing that was best, the best thing that worked for me was jail. See when I was in jail I was just sitting in my cell like for three days and that was it really. Just left to do it on yourself. Felt rough for a few days but you just did it see” (1.4).*

*“You know, the prison environment is, in some respects, perfect for detox. Cos you know, there’s nothing you can do about it, you can’t take anything” (5.7).*

However, despite each of the subjects getting clean whilst in prison, every one of them returned to using heroin once they were released. Again, this was put down to the individuals returning to their drug using lifestyles as well as the fact that they had not received any counselling or rehabilitation whilst in prison. This appears to be a very important oversight of prison drug treatment agencies, as prison appears to be

the perfect environment for heroin dependent individuals to overcome their addictions.

*“I’d go to prison, get clean, come out clean then go back on gear” (1.1).*

Overall, every individual in this study felt that their ideal opiate treatment program would be very similar to the services that they had received at the abstinence-based structured day care program. The most important features were the use of subutex (discussed in Section 4), adequate counselling, both one-to-one as well as a group, abstinence and general feelings of support and understanding from the staff members.

*“...this place, probably nothing else would’ve worked other than this place” (4.3).*

*“I had to come to a place like this where you can’t have anything at all for it to work” (7.3).*

*“Obviously medication, counselling. Basically what they do here. I wish I had found this place years ago” (8.1).*

## **Summary**

In summary, five main themes have emerged through the Grounded theory analysis, each with a number of related sub-themes. All of the themes are related to the subjects’ views and experiences with substitute prescribing, with the emphasis placed on methadone and subutex. Despite the themes having been presented separately, there are clearly aspects of certain themes that are related and overlap with other themes.

## Discussion

The purpose of this study was to consider heroin users' views on substitute prescribing, paying particular attention to methadone and subutex. The majority of the subjects in the study had had previous experiences on methadone programs, and were retrospectively considering their experiences. All of the subjects were recruited through an abstinence-based rehabilitation program where they were currently being prescribed subutex, or had recently completed their subutex program. Through detailed analysis using the Grounded theory approach (Glaser and Strauss, 1967), five main themes emerged, each with numerous sub themes. Although the five themes have been presented separately, they are clearly interrelated, with some aspects of themes heavily dependent upon other themes.

The first major theme to emerge was the participants' reasons for seeking and obtaining a methadone prescription. The participants in this study stated numerous and varied reasons for obtaining a methadone prescription. However, twelve main motivational factors did emerge. It became clear through analysis that participants' reasons for obtaining a methadone prescription would change depending on whether it was their first prescription or a later prescription. Interestingly, nearly all of the subjects initially obtained a methadone prescription with the intention of using it to *abstain* from illegal substances, including heroin. This finding supports that of McIntosh and McKeganey (2002) who reported that the majority of heroin users seek treatment with the intention of abstaining from illicit substances. However, none of the subjects in this study successfully completed their methadone programs, and within six months of obtaining their prescriptions all were back to using heroin as well as the methadone.

When later methadone prescriptions were obtained, the majority of the subjects stated that their intentions had changed, and as opposed to abstinence, they were seeking a methadone prescription with no intention of ceasing their use of heroin. The change in views expressed by the participants suggests that their initial experiences with methadone were not as they had hoped, thus they had given up on the use of methadone as an effective substitute drug, and were therefore using it to abuse. In most cases the abuse took the form of either using heroin in conjunction with methadone, or selling the methadone to fund their heroin addiction. The ease of abuse of methadone has been widely documented across Britain (Bertschy, 1995; Dark et al, 1996) and continues to be a problem plaguing the use of methadone as a

substitute drug. Future studies could consider what factors play a role in changing individuals' intention for methadone prescriptions, and focus should be placed on making the first methadone prescribing treatment program as successful as possible.

All of the participants stated that they obtained a methadone prescription to take the pressure off the demands that their addictions had on their mental and physical health. As noted by Wall (2001) and Koester and colleagues (1999), even brief encounters with methadone programs can result in the individual successfully achieving a personal goal, such as taking a break from heroin use. Even though none of the subjects abstained from illicit substances for longer than six months, the methadone prescription may have reduced their heroin intake, thus improving their health. Biernaki (1985) highlighted the importance of 'pilot testing' treatment programs, as experiencing drug free episodes may encourage the individual to seek treatment on a more permanent basis at a later date. This can be seen to be the case with the subjects in this study as their unsuccessful experiences with methadone programs led them to try subutex programs at a later date.

The reasons for seeking a methadone prescription that emerged in this study were different to the findings of Sell and Zador (2004). The discrepancy in findings may be explained by the differences in research methods used between the studies, as Sell and Zador employed a quantitative approach whilst this study adopted a qualitative method. Smith (2001) supported the importance of qualitative research as he felt it enabled the capturing of emerging themes and concepts, as opposed to reducing individuals' thoughts and experiences to quantitative categories. The main reasons for obtaining a methadone prescription that emerged in this study were, however, supported by Neales' (1999) qualitative study. The variation between the findings of quantitative and qualitative research draws attention to the importance of applying both types of research to obtain a more complete picture of heroin users' perspectives of substitute prescribing.

As all of the participants had unsuccessful attempts at recovery whilst using methadone, this study was unable to distinguish whether those who sought treatment for reactive reasons or due to being ordered into treatment had a lower success rate, as posited by Prochaska and DiClemente's (1992). Future studies could consider these aspects with regard to retention in treatment.

The second theme to emerge from the analysis of the interview material was the users' views on, and experiences with, methadone programs. None of the participants in this study had had successful attempts at abstaining from illicit drugs for a prolonged period, through the use of methadone programs, and only seven of the nine participants had chosen to seek treatment through a methadone program. This supports research which has reported that methadone programs are associated with limited patient acceptance (Kolar et al, 1990; Schottenfield and Kleber, 1995). The participants' views and experiences with methadone programs were extremely negative thus, it can be assumed, that this played a role in their unsuccessful attempts at recovery. The negative views expressed by the subjects in this study are supported by the findings of Rettig and Yarmolinsky (1995) who noted that a third of clients leave methadone treatment within the first year.

No positive aspects of methadone programs emerged in this study, which supports the findings of Kolar and colleagues (1990). The subjects' negative views were based upon their own experiences with methadone programs as well as the experiences of acquaintances, a finding supported by a number of researchers (Flaherty et al, 1980; Koester et al, 1999; Hunt et al, 1986). All of the participants expressed that they had received inadequate counselling services whilst on a methadone program and that this factor had played a major role in their failed attempts at overcoming their heroin dependency through a methadone program. This finding was supported by Neales' (1999b) study and Fiellin (2002), who reported that counselling plays an important factor in retention in treatment and recovery from heroin addiction.

The subjects in this study also reported that the treatment programs that they had experienced were too generalised and did not account for individual differences between clients. This notion is supported by Edwards and colleagues (1997) who highlighted the between-person variations noted within treatment research and emphasised the importance of providing individualised treatment plans. The need for individualised treatment programs was also reported in Fisher and colleagues (2002) and Neales' (1999b) qualitative studies on users views of methadone programs. Neale (1999b) also supported the findings of this study with regards to the need for more adequate drug screening services. These drug screening services were reported to reduce illegal drug use, thus promoting abstinence from illicit substances whilst on substitute prescribing treatment programs.



Subjects in this study also felt that the stigma surrounding heroin use and the negative attitudes of the staff of many methadone programs had detrimental effects on the outcomes of their experiences with methadone treatment. As reported by Metrebian (2001), the stigma surrounding heroin and heroin use has been noted to play a major role in the difficulties with measuring the extent of heroin use within Britain. The negative attitudes expressed by the staff of treatment programs to the subjects in this study evidently resulted in enhancing the negative views held towards methadone programs, thus damaging methadone's reputation as a substitute drug. To enhance the effectiveness and general acceptability of methadone programs among heroin users, efforts should be made to make the clients feel more at ease in their surrounding by educating the staff about the nature of heroin addiction.

The third theme to become apparent in this study was the users' views on methadone as a substitute drug. Based on personal experiences with methadone, alongside observations of others using methadone, every participant strongly believed that methadone was an extremely poor substitute drug for the treatment of heroin addiction. This finding concurs with a number of other studies which have also reported that heroin users have very negative opinions of methadone (Flaherty et al, 1980; Koester et al, 1999; Hunt et al, 1986). Further support for these findings comes from the qualitative studies of Neale (1998) and Fischer and colleagues (2002).

The two most commonly cited negative aspects of methadone were its addictiveness and the fact that it does not prevent the individual from using illicit substances as well as using the methadone. A number of studies support these findings ((Beschner and Walters, 1985; Hunt et al, 1986; Koester et al, 1999; Rosenblum et al, 1991) and it can be assumed that these negative views on methadone are, in part, responsible for the overall lack of acceptance for methadone and methadone programs reported among heroin users (Koester et al, 1999; Hunt et al, 1986). These two negative aspects of methadone can both be overcome by the use of subutex which has been reported to be less addictive than methadone (Robertson et al, 1993; Cheskin et al, 1994), whilst also blocking the effects of exogenous opioid administration (Mello et al, 1981).

The ease of abuse of methadone was a further negative aspect of the drug expressed by the subjects in this study. This finding was also voiced by the participants in Fisher and colleagues (2002) qualitative study. The abuse of methadone continues to be a major problem surrounding the drug (Godfrey and

Sutton, 1996), with many researchers proposing that its abuse is widespread in some areas of Britain (Dark et al, 1996). The use of a combination of subutex and naloxone may hold the key to reducing the abuse of substitute drugs, as naloxone will prevent intravenous usage (Robertson et al, 1993; Gossop et al, 1999).

The control that methadone prescribing exerts over an individuals' life was also frequently mentioned as a negative aspect of methadone. The majority of the subjects stated that the restrictions imposed upon their lives due to the daily collection of their prescription was a reason why they chose to cease their use of methadone. This finding was supported by Fischer and colleagues (2002) study, and may help to explain the low retention rates in methadone treatment reported by a number of researchers (Bertschy, 1995; Hubbard and Marsden, 1986; Rettig and Yarmolinsky, 1995). Again, the use of subutex as a substitute drug appears superior to methadone as subutex can be effectively administered thrice-weekly (Gossop et al, 1999), thus reducing the restrictions imposed by prescription collection. Further support for the use of subutex, as opposed to methadone, as a substitute drug comes from the participants' views that the time taken to complete methadone treatment is too long. As the time taken to complete subutex treatment programs is far shorter, heroin users may be more likely to engage and remain in subutex treatment, in comparison to longer term treatments such as methadone programs (Fiellin et al, 2004).

The number of participants expressing positive views on methadone was considerably lower than those expressing negative views. The positive views were also cited less frequently and in many incidences were in response to questioning such as "What are the positive aspects of methadone?". The majority of participants did state that methadone effectively eliminates the withdrawal symptoms from heroin, which is supported by a number of previous studies (Schafer, 1997). However, this was evidently not sufficient for the participants to complete their methadone treatment programs, and from this study it can be seen that the negative aspects of methadone clearly outweigh the positive aspects.

Participants did state that whilst on methadone they experienced periods of abstinence which ranged from a week to six months. These periods of abstinence may have been sufficient in successfully achieving the individuals' goal for treatment at that time (Koester et al, 1999; Wall, 2001), whilst alleviating the pressures exerted upon the subjects' mental and physical health. A small number of subjects also

expressed the belief that methadone treatment programs could play a part in treatment for some individuals, which supports Edwards and colleagues (1997) notion of the importance of variations between individuals in their specific requirements for treatment. Overall, the negative and positive views expressed by the subjects in this study are supported by a number of other qualitative and quantitative studies (Fischer et al, 2002; Koester et al, 1999; Neale, 1998).

The fourth theme to emerge from this study was the subjects' views on subutex as a substitute drug. All of the participants in this study were currently abstaining from illicit substances through the use of a subutex prescription, or had successfully completed their subutex treatment program. In contrast to the subjects' views on methadone, the participants' views on subutex were extremely positive, with only two negative aspects of the drug emerging through analysis. All of the participants stated that they thought that the positive aspects of subutex combine to make it the best available substitute drug, and all of the subjects' experiences with it had been far more positive than their experiences with methadone. However, it must be noted that the subjects' positive views on subutex may be due to the effectiveness of the combination of the treatment program and the use of subutex.

Every participant expressed that one of the major advantages that subutex has over methadone is that it is a partial agonist with antagonist properties that do not allow the effects of any illicit drugs to be experienced (Jasinski et al, 1978), thus abstinence is promoted. All of the subjects stated that abstinence plays a major role in the success of subutex as a substitute drug and all were very optimistic about abstinence-based treatment programs. A further positive aspect of subutex expressed by the subjects was the speed of the treatment programs which can be completed in a far shorter time than methadone programs. This is supported by Fiellin and colleagues (2004) who posited that the shorter-term medical withdrawal from heroin through the use of subutex would be far more appealing to clients than longer-term treatments such as methadone programs.

Just over half of the subjects stated that they experienced difficulty whilst on the lowest doses of subutex and also that subutex has the potential to be abused. Although individuals on subutex may experience some discomfort whilst on the lowest doses, the partial agonist properties of subutex mean that there is an easier withdrawal process than that experienced by methadone withdrawal (Robertson et al, 1993; Cheskin et al, 1994). The issue regarding the abuse of subutex can also be

overcome by the use of a combination of subutex and naloxone which has properties that prevent intravenous use (Robertson et al, 1993).

The final theme to emerge from this study was the users' views on their ideal opioid treatment and the factors that would lead to a successful recovery. All of the participants in this study spontaneously expressed very strong views regarding their ideal opioid treatment, despite there being no direct questioning regarding this issue. The low levels of satisfaction with treatment programs reported in this study are supported by the findings of Sell and Zador (2004) who reported that 59.6% of their sample wanted immediate changes to the structure of treatment programs. The majority of subjects in this study stated that they had very high levels of satisfaction with their current treatment programs, although the subjects' views on their previous experiences with methadone programs were very negative. However, it must be taken into consideration that the subjects were looking back at their experiences with methadone programs retrospectively, and with the ability to compare them to their current, successful program.

One of the factors that all subjects felt particularly strongly about was the need for adequate counselling, which many of the subjects felt had been missing from their experiences with methadone treatment programs. Participants especially expressed the need for one-to-one counselling, which is supported by Fischer and colleagues (2002) whose subjects expressed that one-to-one counselling should be mandatory. Group therapy also emerged to play an important role in rehabilitation, as the subjects felt that they could relate with the others in the group, thus reducing their feelings of isolation. Subjects also felt that counselling received from an individual who had themselves experienced active addiction was a lot more beneficial than counselling from someone who had not had such experiences. Again, this view was related to the fact that the subjects could connect more easily with those who had similar experiences.

Overall, the subjects clearly stated the importance of rehabilitation rather than the emphasis being placed solely on detoxification. A large proportion of the subjects stated that the counselling was essential in the fact that it enabled them to get to the root cause of their addiction, thus enabling them to sort out the initial factors that lead them to their heroin addictions.

Participants also stated that being ready to get clean and wanting to get clean were important aspects of recovery from heroin addiction and played a major role in retention in treatment. Subjects stated that if they were not ready for treatment then it would not be successful, as the individual would not wholeheartedly be trying to overcome their addiction. This finding is supported by Prochaska and DiClemente's (1992) model of change which posits that an individual has to be ready to overcome their addiction, otherwise no interventions will affect their behaviour. The importance of wanting to get clean for themselves was also a significant factor expressed by the subjects, as they have to be willing to leave behind a major part of their lives. As stated by Stephens (1991), the role that heroin plays in opiate-dependent individuals' lives may be sufficient to dissuade them from seeking treatment; thus, the individual has to want to leave that lifestyle behind and move on. Reaching rock bottom was also expressed as playing a role in helping subjects feel ready for treatment and wanting to overcome their addiction. As expressed by the subjects, an individual can not battle their way out of addiction until they have become so low that they really want to escape the life and lifestyle of heroin use.

All of the subjects in this study stated the importance of making life style changes and learning coping mechanisms during the rehabilitation stage of treatment. This relates back to the importance of counselling, as it provides the individuals with the knowledge of how to make changes to their behaviour so that they will not return to their drug using social circumstances on completion of treatment. The importance of making lifestyle changes when overcoming addiction have been supported by the findings of Vaillant (1996) and Robins (1993) who highlighted the importance of social context in addiction and recovery. A number of researchers have also proposed that acquiring a substitute behaviour that competes with the addiction plays a major role in overcoming addiction (Miller, 1993; Brownwell et al, 1980), a view point agreed on by the subjects in this study.

Nearly all of the participants stated that abstinence based treatment programs were, for them, an essential part of the recovery process. By using subutex, which prevents the pleasurable effects of illicit opioids (Jasinski et al, 1978), the temptation to use illicit drugs is taken away from the individual, so they are then able to focus on the issues that lead them to addiction. However, the subjects used in this study were a biased sample as they were all recruited from the same abstinence-based treatment program; thus, they believed that abstinence is a key aspect of recovery. The subjects did note the importance of individualised treatment programs as each heroin

user has different wants and needs, and all have had different experiences throughout their addictions. Retention rates in treatment should also increase if more time was spent with each individual to determine the best course of treatment. Although there may be more expense initially with individualised treatment programs, in the long run the costs would be cut as the relapse rate should decrease thus the number of times an individual enters treatment should decrease.

An interesting factor that emerged from the analysis of the interview material was the subjects' views on their experiences with prison. Four of the participants had spent time in jail during their addiction, and all of them had successfully detoxified off heroin without any pharmacological help other than over-the-counter medicines prescribed by the prison doctors. On their release from prison, all had intended to refrain from illicit drug use; however, within short periods of time, they were back to using heroin again. During their time in prison, none of the subjects had received any specific counselling regarding their heroin use; thus, they had received no rehabilitation to assist them on their release from prison. Future studies should consider this aspect of the prison service, as prison sentences appear to be an ideal time to focus on rehabilitating drug users as, in many cases, the individual has no option but to refrain from using illicit substances during their sentence. Potentially drug using individuals in prison could be targeted for rehabilitation programs so that on their release they are prepared with the lifestyle changes and coping mechanism that are vital in overcoming heroin addiction. By placing opiate dependent prisoners on subutex, the chances of them using illicit substances whilst in prison are also extremely reduced, thus all focus could be placed on rehabilitation.

Overall, through the analysis of the data five main themes emerged, each with a number of sub-themes. A number of interesting factors have emerged that could be the focus of future studies. There clearly appears to be a discrepancy between studies considering the users' views on substitute prescribing that have used quantitative research methods and studies that have used qualitative research methods. A striking example of this is with regard to the effectiveness of methadone in comparison to subutex. Although there has been extensive quantitative research comparing the two substitute drugs the results are often varied. However, a larger proportion of studies have reported methadone to be superior to subutex in retention in treatment. In contrast, the subjects' views from this study, as well as from a number of other qualitative studies (Fisher et al, 2002; Koester et al, 1999; Neale, 1998), have largely favoured subutex over methadone.

With the majority of manufactured products, the users' views are extensively analysed to ensure a product that is closely related to what the consumer wants. However, with substitute drugs this does not appear to be the case. Future studies could combine quantitative and qualitative approaches to produce services to heroin users that most closely match their needs. This study has shown that subutex has far more attractive qualities to the consumer than methadone does. However, 90% of the British in-treatment heroin dependent population are currently being prescribed methadone (Strang et al, 1996). Further clinical studies comparing the efficiency of methadone and subutex should be conducted. However, higher doses of subutex should be tested as doses of up to 32mg are licensed for use in Britain, which may have a substantial effect on the results.

Although there are a small number of qualitative studies regarding users' views of methadone and methadone programs, there are no studies that consider the consumers views on subutex and subutex programs. Largely this can be answerable by the fact that, in comparison to methadone, subutex is a new substitute drug. However, it is imperative that future studies consider the users' views and experiences with subutex to determine whether it should become more widely and readily available across Britain. The combination of subutex and naloxone appears to provide the solution to the majority of the negative aspects of subutex. Thus, future studies should also focus on the users' views of this new combination.

Although the sample used in this study was biased, their experiences with the abstinence-based structured day care treatment program were clearly very positive. The constructive aspects of such programs should be taken into consideration for the basis of other treatment programs to enhance customer satisfaction as well increase retention rates in treatment. Future studies could consider the view point of subjects from different treatment agencies to determine the most successful aspects of each program. Ideally, studies could follow participants' progress from when they first enter treatment, so that the subjects' views would not be prejudiced by their experiences within the treatment program. This study was unable to this due to limitations with time, cost and availability of participants. However, future studies may be able to overcome these problems.

The experiences described by the subjects in this study may have been tainted due to biases in their retrospective memories. This limitation is specifically relevant with

regards to the subjects' views on methadone programs, as a number of the subjects had experiences methadone programs a number of years ago. Again, this could be over come in future studies by following participants experiences through different treatment programs, although this could clearly be a very time consuming and costly project. It would also be interesting to consider whether heroin users from different areas of Britain have had different experiences with treatment agencies, with, again, the aim being to focus in on the most positively portrayed aspects of treatment programs.

In summary, this study has supported previous qualitative studies regarding heroin users' perspectives of substitute prescribing (Fischer et al, 2002; Koester et al, 1999, Neale, 1998, 1999a, 1999b). However, it has emerged that subutex is viewed as a far more attractive substitute drug than methadone, which is in contrast to clinical studies which compare the efficacy of methadone and subutex (Kosten et al, 1993; Ling et al, 1996; Schottenfield et al, 1997; Fischer at al, 1999; Petitjean et al, 2001). This discrepancy in findings supports the need for further qualitative research into drug misusers' perspectives and experiences with the services that are provided for them. A number of interesting avenues for future research have emerged through this study. In particular, there is a great need for qualitative studies, specifically regarding heroin users' views and experiences with subutex and subutex/naloxone.