Form or content: The application of user perspectives in treatment research

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Abstract
As part of a general trend in modern society, the voice of the ‘consumers’ of the services of the welfare state has gained increased legitimacy. However, this is not the case when it comes to drug-treatment users. The continuing neglect of this group’s experiences is also reflected in methadone maintenance treatment research. This article seeks to counter this imbalance by exploring users’ experiences with enhanced psychosocial methadone maintenance treatment. The findings rest on an evaluation of the Danish Methadone Project. As part of the evaluation 37 semi-structured qualitative interviews with users were made, and two months of participant observation were conducted in the clinics. An important finding is that the users highlighted the form of the treatment as much as the actual content. It was not primarily the content of the services, but how the services were carried out that mattered. Most crucially, the users highlighted the attitude of the counsellor, the accessibility of spontaneous counselling, and spaces that facilitated non-stigmatizing social encounters. While drug users do not provide the definitive statement about the value of drug service provision, listening to their voices is a necessary step in building an ethically sound approach to drug treatment, with a high degree of client support where the treatment provided meets the consumers needs.

Keywords: Drug-treatment research, users’ view, drug services, psychosocial methadone maintenance treatment

Introduction
Over the last decades, contemporary Western society has moved from being an industrial society to a consumer society. Identity and social status are more and more linked with patterns of consumption, whereas traditional roles of occupation have declined in significance (Featherstone, 1991; Giddens, 1991;
Seljestad, 1997; Sulkunen, Holmwood, Radner, & Schultze, 1997). This shift has had direct bearings on the contemporary understanding of being a user, simply because, by the very act of consuming, one is automatically seen as a user with a legitimate voice regarding the product of which one is a consumer. In relation to the services of the welfare state the philosophy of consumption has gained a foothold, which has given the voice of users growing legitimacy (Barry, Osborne, & Rose, 1996). However, the most active and strongest pressure groups (consumers/users) are granted the largest advantages. So even though the voice of marginalized people such as drug addicts has been placed on the agenda of social policy in many North European countries in the last couple of years, the significance of this voice is still minor, which is probably due to the fact that ‘this sector of the population is rarely seen as a vocal consumer group, whose expectations need to be taken into account in designing or operating efficacious programs’ (Hunt & Barker, 1999, p. 130; see also Asmussen & Jöhncke, 2004).

This neglect of the voice of drug addicts is also reflected in methadone maintenance treatment research and evaluation. Here the focus has been more on documenting the efficacy of treatment services and isolating the factors associated with outcome (for example dose level and treatment duration) than on representing the user perspective (Conners & Franklin, 2000; Hunt & Barker, 1999; Lilly, Quirk, Rhodes, & Stimson, 2000). The exceptions to this general trend only prove the rule (some exceptions have come about in recent years: Åberg, Grönberg, Persson, & Gerdner, 2001; Asmussen & Kolind, 2005; Bourgios, 2000; Conners & Franklin, 2000; Hunt & Rosenbaum, 1998; Jöhncke, 1997; Koester, Anderson, & Hoffer, 1999). This paper aims to even out this imbalance by representing users’ experiences with enhanced psychosocial methadone maintenance treatment. I view drug addicts’ voices as a legitimate and valid aspect of the evaluation of drug treatment and find it just as relevant to include their experiences when evaluating drug treatment, as it is to include patients’ experiences when assessing medical services, or the views of train passengers when considering train services. In fact, it may be even more relevant, since drug treatment is embedded in control policies, which often only offer limited choices. I do not suggest that drug users provide the definitive statement about the value and efficiency of drug service provision. Nevertheless, their experiences and views are important when planning relevant drug treatment. It is reasonable to suggest that agencies are more likely to be effective if users feel that the services provided serve their ends (see also Neale, 1998).

One can validate the voice of drug-treatment users in two ways. First, their perspective can be used as a kind of quality assessment in which drug-treatment users are asked to assess certain services by standardized measures (see, for example, Åberg et al., 2001). Second, one can engage in a more explorative research strategy and permit users to introduce issues, which they find relevant in relation to treatment arrangement, issues that one as a researcher does not necessarily know about in advance. Ideally, one opens up the possibility for the introduction of new agendas, and for getting answers to questions that one as a researcher could not ask. Such a methodology comes...
close to an anthropological epistemology, in which the focus is on the actions and subjective perspectives of actors and the meanings that people place on events, processes and structures of their lives (Agar, 2002; Hammersley & Atkinson, 1995).

Koester et al. (1999) engaged in precisely such an explorative research design, which meant that their study began as a users’ view of drug treatment and evolved into an investigation of drug users’ alternative motives for seeking treatment. These motives could not have been detected if they had restricted the research to only evaluating the professional treatment model. The researchers found that drug users sought methadone maintenance treatment in order to stabilize their life, preserve jobs, and reduce the likelihood of violence, or as the authors put it: ‘self-prescribed attempts at harm reduction’ (Koester et al., 1999, p. 2137). Or the users sought treatment as a kind of ‘pilot test’ of what a life without illicit drugs use may be like. In sum, this research strategy yielded situationally based understandings of treatment, which could not be comprehended in light of the unconditional definitions applied by the professional treatment model. Lilly et al. (2000) found that a central aspect of drug treatment is embedded within the negotiation and building of social roles and relationships between the counsellor and the user. They mentioned negotiations of roles such as: friend, confidante, therapist, treatment expert, and professional. Treatment, they argue, should therefore be seen ‘as a social interactional process and not merely as a medical encounter with a treatment outcome’ (Lilly et al., 2000, p. 163). And Hunt and Rosenbaum (1998) found that methadone maintenance treatment, as seen from the client’s perspective, can not be understood without considering the wider social context of the clinic. For many clients the clinic is both a therapeutic institution and an institution of social control. And though many wanted to give up life on the street, they hesitated and were reluctant. The clients felt uncomfortable with the clinic’s control regime in which they felt treated as criminals rather than patients, and as errant children rather than adults. As a consequence, many of Hunt and Rosenbaum’s informants imported hustling skills learned on the street into the clinic in order to negotiate that difficult world. They switched urines to avoid detection of drug use and they sold take-home doses in order to pay clinic fees.

On the basis of similar methodological assumptions, this article argues that users (of the Methadone Project outlined below) often highlight the form of treatment more than the actual content. Pushing this insight to its logical conclusion, I contend that the counsellors’ attitudes and the structural arrangements of time and space of the treatment was as important for the users as the actual services provided. In the rest of the paper I will develop this argument further.

Data

The data for this article were collected as part of an evaluation of the Danish Methadone Project carried out by The Centre for Alcohol and Drug Research.
at the University of Aarhus from 2002 to 2005. The Methadone Project was initiated and financed by the Danish Government. The general aim was to examine whether enhanced psychosocial methadone maintenance treatment could make improvements in areas of drug users’ living conditions where standard methadone maintenance treatment has only limited or no effect. In general the following concerns separated the enhanced treatment in the Methadone Project from standard methadone maintenance treatment: a lower client–counsellor ratio (1–10/15 versus 1–20/40); more frequent and more accessible individual counselling (scheduled as well as spontaneous); outgoing help; co-ordination of treatment (activity plans and case management); drop-in centres open more than 3 hours a day; user participation; health-related services; and experiments with methadone dispensing (such as intravenous methadone and individual face-to-face flexible dispensing). The project was divided into four subprojects located in different parts of Denmark, and for three years the subprojects supplemented standard methadone maintenance treatment in these areas. In Denmark all in-patient methadone maintenance treatment is state sponsored. For three of these subprojects the target group was the most extremely affected drug user, selected on the basis of definite criteria, such as being over thirty years of age, having more than ten years’ history of heroin abuse, having tried many various forms of treatment programmes and so on. As such, they were users known to the treatment systems, but who could not be kept in treatment or who had not benefited from the treatment they were already undergoing. In contrast to these three subprojects, the fourth did not have a defined target group. In all there were 126 users enrolled. Of these, 111 were interviewed by May 2003 (intake interview) using Europ-ASI. Of the 111 27 (24%) were female and 84 (76%) were male. The median age was 38.4 years. In relation to housing conditions, employment and education the users in the Methadone Project were similar to users in Danish standard methadone maintenance treatment. However, looking at the results from the addiction severity index in Europ-ASI in relation to drugs, alcohol, physical and psychic condition, and network, the users in the Methadone Project were significantly more severely affected (Asmussen, Kolind, & Pedersen, 2003).

The evaluation of the Methadone Project consisted of both a quantitative (Pedersen, 2005) and a qualitative part (Asmussen & Kolind, 2005). The qualitative evaluation had five focal points: (1) an outline of the content of enhanced psychosocial treatment; (2) user participation; (3) co-ordination of treatment; (4) treatment ideologies; and (5) users’ experiences with the treatment. This article deals mainly with the last issue. In order to explore the users’ experiences with the treatment offered in the different subprojects, we did 37 semi-structured qualitative interviews with users, as well as conducting two months of participant observation in the four treatment centres. In the interviews we explicitly focused on the users’ views and experiences of the specific services of the different treatment programmes. All the interviews were transcribed and subsequently coded in NVivo.
The argument

Each of the four subprojects of the Danish Methadone Project had wide powers in defining the content of their individual institution’s treatment programmes. And, not surprisingly, a range of dissimilar treatment services was tried out. Examples include: acupuncture, user meetings, counselling (individual and group), educational and employment opportunities, excursions, outside activities, food (breakfast/lunch), social activity plans, massage, medical care, methadone maintenance treatment, monitoring, physical activities (e.g. visits to fitness centres and swimming pools), personal skills training, therapy (individual and group), a vaccination programme, and workshop activities (e.g. sewing, video projects, and computer literacy).

When we interviewed the users in the four different projects, we explicitly asked for their views of these diverse treatment services. The users’ comments were more similar than diverse, with the similarities cutting across the actual treatment services provided. In short, it was not primarily the content of the services, but how the services were carried out that mattered. Seldom did users emphasize specific services. Instead they called attention to the counsellors’ attitude and the circumstances of the treatment—reflected for instance in what users referred to as ‘the spirit’ of the individual project. It was, then, the philosophy of the treatment setting that mattered the most for the users. A philosophy, which for all the projects shared some basic tenets. Most important among these were the staff’s explicit focus on building trustful, equal, and respectful relations to the users; strategies of normalization, which meant that the staff at one and the same time tried to destigmatize and educate the users; and a rather pragmatic approach to the users, which meant that the staff to a high degree wanted to help the user with what he/she experienced as being most urgent (which was not necessarily drug addiction). For an elaboration of the treatment philosophies of the Methadone Project see Asmussen (2006) and Asmussen and Kolind (2005).

In general, then, the inquiry into users’ experiences of enhanced psychosocial methadone maintenance treatment failed to reveal any individual treatment services as superior or preferable. In order to understand this finding an analytical grouping can be made. In the following I will distinguish between the services and the framework in which these services are offered. The framework is related to the dimensions of time, space and attitude. The aspect of time centres on the users’ experiences of the accessibility of outgoing help and the availability of counselling. Space primarily relates to the users’ experiences with the projects’ drop-in centres. And, finally, attitude refers to users’ views of the attitude and approach of the counsellors.

The attitude of the counsellor

In all of the four subprojects, the individual users were attached to one main counsellor, a contact whose work by and large can be characterized as a loose form of case management [1]. The first aspect that users emphasized relates to
the way in which the case manager interacted with them. Most importantly, users highlighted the feeling of being treated respectfully, along with the feeling that ones’ case manager cared and, more generally, that anyone whatsoever cared. Users have stressed that a personal relation to a case manager, whom they found respectful and engaged, was the most important part of the treatment. In fact users’ personal relation to their case manager can be seen as the ‘gateway’ to the programmes’ services. That is, users did not participate in the different services necessarily because of the content of this or that service, but because their case manager introduced or guided them towards these services (see Lilly et al., 2000, p. 166, for similar observations). In the following passage a user, who has being taken to a hospital in relation to a heavy alcohol problem, tells about a counsellors’ respectful attitude:

My contact person came to the hospital. He coddled me, and he was just so great. For the first time in my life I was given flowers when in hospital. You know, for me it is the small things that mean a lot. When I was in hospital for twenty-six days, my girlfriend never once brought me flowers. No, she came and asked if I could stow away some of the medicine I was getting for her. That’s what addicts are like. When I dried out, I suddenly realized how much the staff at the project were really interested in helping me. Helping little me. Never in my life as a drug addict had I experienced such a huge effort to help a single person.

As the passage makes clear, it is the attitude of the case manager that stands out and counts the most. Previous research has shown that out-patient methadone maintenance treatment has been experienced by users as being impersonal, marked by control and distrust, and with limited room for empathy (Bourgios, 2000; Frantzsen, 2001; Hunt & Rosenbaum, 1998; Jöhncke, 1997). On this basis it is perhaps not so remarkable that users emphasize what they see as their case manager’s trusting engagement.

Users also stress that their case manager takes them seriously, understands their situation and listens to their own presentation of their problems in an open manner—that they are not, as a user expressed it, admonishingly telling them what is right and wrong. Of special importance here is the feeling of being able to talk with the case manager about supplementary use of illegal drugs and developing individual strategies for a possible reduction thereof. Users tell how, in previous methadone maintenance treatment, they experienced sanctions, even expulsion, if they told about any supplementary use, or if it had been revealed (for instance as a result of urine screening). Therefore many users have spent a lot of energy on hiding or denying any supplementary use.

Users also stress that their case managers in the projects have been good at decoding their problems and at sensing if something was wrong. This has been of central importance when the user him-/herself has lacked the energy to bring attention to the predicament. As one of our informants explains about the treatment programme:

I feel here is everything you need. One just has to open one’s mouth. But even if you don’t speak, they notice if something is wrong. They know if there is something we have to talk about. And it is always: ‘How is it going, shall we talk?’ They are in control of their children [users].
In sum, users emphasize the feeling of trust and care displayed by their case manager, and they draw attention to the importance of the user and the case manager getting on well together.

Even though a great many of the users developed close relations with their case manager many of them also stressed the importance of the case managers’ ability to sustain a professional detachment towards their users. This relates to the fact that many of the users of the treatment programmes valued being held to decisions. They valued the fact that their case manager took charge of things and insisted on carrying through arranged plans. And users appreciated when the case manager provided straightforward responses and when he or she did not accept all of the users’ statements at face value.

The case managers’ attitude is thus of special importance to the users. Whether one treatment method or another inspired him/her or whether emphasis was on one service or another was not of key importance for users. Focus was on attitude, on trust, respect, sincerity, and professionalism.

Time

The second structural framework relevant to understanding the users’ experiences with the treatment programmes relates to time. For users this meant availability of counselling and it meant accessibility of outgoing help.

In relation to availability of counselling, users stressed the importance of being able to consult their case manager spontaneously (see also Bacchus et al., 1999). For many drug users problems arise in an acute manner, and in the projects it has been of great importance for users that counsellors could be contacted if the user became sad or experienced insurmountable personal problems. Several times informants stressed that in the present treatment programme (contrary to standard methadone maintenance treatment) they did not have to arrange for meetings with their case manager, they could just ring him or her, or they could show up at the drop-in centre. And even if he or she was busy they seldom had to wait long. As a consequence users primarily valued counselling with a focus on problems related to the here and now, whereas counselling pointing forward and with focus on planning was secondary. This experience of the availability of counselling naturally has to do with the counsellor–user ratio, which in the projects was low (1–10/15) compared to standard out-patient methadone maintenance treatment in Denmark (1–25/40; Pedersen & Asmussen, 2002). However, when some users emphasized that their case manager always had time for them, they also referred to a more general attitude related to these users’ general feeling of being treated respectfully. The close connection between time and the respectful attitude of the counsellor in the eyes of the users can be seen in the following quotation. The user has been through some periods of heavy depression and he especially values the counsellors’ support in these periods:

If the staff can see that you need to talk, they almost always have time. Even though they have had a rotten day, they normally smile and are able to talk properly. And that has been an
invaluable help. To be able to utilize the facilities—yes, but most of all the people who are here. Most of us who come here, well we have associates, but those associates are drug addicts. And a lot of us need somebody to talk to. You know, discussing private stuff and maybe receiving help to deal with personal problems. Often I have also lacked the energy to for instance deal with letters from the Welfare office. And it has simply been a relief that I could ask: ‘Can I get some help with that?’ And it has never been a problem: ‘Of course you can.’ Because when I started here [in the project] the way I looked at the world was like fuck it all. Now this has been changed through my case manager.

Not all used their case manager to the same extent. But for a large number of the users the continuous and spontaneous talks were rather important.

The second aspect of time relates to accessibility of outgoing help. An aspect of this help has to do with what some counsellors termed ‘cleaning up chaos’, that is escorting or helping the user in his or her contact with different institutions such as the hospital, the health centre, the welfare office, the police, and the dentist. The users know that they often have difficulties getting things done without support. And they state that meetings with public servants are less problematic and more constructive when their case manager accompanies them. As users explain it, the case manager can help remember the agenda of the meeting and afterwards they can talk about the outcomes of the meeting. In addition users value the support of the case manager in such encounters because they feel that they then get a more decent and fairer treatment. A user tells how his case manager escorted him to his social worker at the local government office:

I don’t think I would have made the meeting without him. He made me pull myself together. I had been talking with a social worker once, and we just started quarrelling. Also telephone contacts have resulted in quarrels. So I wanted my case manger to assist me. Besides, I know if I come alone, they do not listen to me. My case manager more or less knows and can remember what I have on my mind. I can’t. I have terrible amnesia when I’m sitting in such a meeting and get stressed.

Another aspect of the outgoing help that users valued relates to the help they have received from their case manager to manage practical everyday matters. They mention such practical tasks as moving from one flat to another, paying bills, doing the shopping, doing the washing, managing the money, and so on. This help is made up of many minor acts, which do not add up to much at first sight, but for the users these elements can be rather decisive.

Time, that is, the availability of counselling and the accessibility of outgoing help, is an important framework for the psychosocial methadone maintenance treatment as far as the users see it. Sometimes the importance of this framework becomes extra clear, as when users say that as much as they value that urgent problems are getting solved, they appreciate and highlight the fact that help is attainable at all; it is the very fact of accessibility that at times becomes as important as the actual services.

Space

In the projects the crucial component in relation to the framework space was the drop-in centres. These consisted of several rooms: for instance TV rooms,
workshop rooms, and common rooms with chairs, sofas, and tables. And methadone maintenance was dispensed individually in tranquil settings in a separate room. The users had also been consulted in relation to the arrangement of the drop-in centres. In three of the drop-in centres breakfast and sometime lunch were offered, and users could always get a cup of coffee. In the drop-in centres different workshop activities were offered, though with rather limited involvement from the users. While in the house, the counsellors were always present in the drop-in centre (except when having private counselling) facilitating informal contact with users. Though differences existed between the drop-in centres our informants drew attention to similar aspects, namely the drop-in centres’ function as the setting for a special kind of social interaction. For employees the centres are the setting for all kind of different services (activities, personal-skills training, food, methadone maintenance dispensing, and so on). For users, however, they are the setting for a special kind of interaction between users themselves and between users and case managers. Again it is the form of the treatment that users highlight.

Users repeatedly said, in interviews and informal conversations, that they appreciate being addressed decently and respectfully by the staff at the drop-in centres. And as a user stated: ‘People notice you in the drop-in centre’. Users simply felt welcome in the centres, and for many such a feeling was a new and pleasant experience. Many drug addicts are used to a high level of stigmatization from the surrounding society. Users said that in the drop-in centres they were treated respectfully for the first time in a long period, and were perceived as whole persons—their non-drug-related identities were valued. A user said about the drop-in centre to which he was attached:

I like feeling welcome, because in many places you do not feel that. And I understand that. Who in the hell wants to let an old drug addict inside? But you feel, well damn it, somebody wants to help you here. People can actually see you, you are not invisible. That’s nice. Everybody wants to be seen, right? And it has been a long time since I have been seen. Normally people turn their face away, and are superior. And that still hurts every time. I also like that we can move freely around the drop-in centre without having them distrusting us. You know, not being suspected, that’s nice.

In the drop-in centre at which this user was a regular visitor only the door to the methadone maintenance dispensing room was locked. In the rest of the house, including the staff offices, users could come and go as they pleased.

For many users the drop-in centres were also important in facilitating informal contact with the case managers. Users told how such contact was extremely valuable, as many of them had difficulties in keeping to scheduled consultations and, furthermore, often experienced acute problems. The informal atmosphere in the drop-in centres also made conversation more natural in the eyes of the users as the user–staff relationship was ‘softened’. Some users said that they felt less like a case and more like a person in these informal encounters.

Users also experienced the drop-in centre as a kind of refuge or shelter at times, a place apart from the stressful life of the drug addict. The users felt safe in the drop-in centres. Such feelings were reflected in the way many users used
the centres. They turned up, had a cup of coffee, had some food, had an informal talk to their case managers and the other users, read a little in a newspaper and had another cup of coffee. On the surface this is a rather passive behaviour, and it was often frustrating for the employees, who wanted the users to engage in more active behaviour, and to make use of the different services that the drop-in centres offered. In fact, many employees wanted the drop-in centres to be more like activity centres, with active involvement of the users. However, one should not underestimate how the users’ relaxed and non-stigmatizing interaction both with each other and the staff in many ways could be experienced as a kind of time-out and as an alternative to the drug-users’ life outside. As an elderly user stated rather bluntly:

Nothing much is happening here. I turn up and have a cup of coffee. Then I go get my methadone maintenance. Then I sit down at the coffee table to have something to eat, and to drink my coffee. Then we sit and talk. If anything is going on, well I join in. It’s up to you if you want something to happen, but I like it the way it is. I think it works really well.

One should keep in mind that three of the pilot projects were focused on the most heavily affected drug users, and it was often these persons who used the drop-in centres as described by the user above. For other users who functioned better, the drop-in centres could in fact symbolize the stigma, which they wanted to escape. Our field-note data show that approximately half of the users used the drop-in centres a lot. A quarter used them sometimes, and the last quarter avoided them. For the last group the drop-in centres at times represent ‘contaminated’ space [2].

In contrast to those who felt the drop-in centres to be polluted by a drug-addict identity, some users experienced the spatial arrangement of the drop-in centres as having a normalizing effect. By being together with other people in ‘normal’ surroundings the gaze of the ‘Other’ suddenly acquired new meanings, as reflected in the following quote:

I can take better care of myself now, and I can keep my flat in order. I can keep it clean and tidy. You know, look clean and well, wash myself and put on clean clothes. Previously, I just went down [to the methadone clinic] to collect my methadone. I just went in, drank my ‘dones’ [methadone] and then out. You did not have to be together with other people, so you could be more like a pig. You did not shower that often. But here [in the project], where we are all together every day, it’s something else. Then you start to think about how you look.

The drop-in centres have an additional function. They were places, which could alleviate some users’ loneliness. Some of the older drug addicts sometimes depicted an existence in which methadone maintenance and the television more or less made up their entire life. The drop-in centres could make life a little more meaningful. They met other people and stressed the pleasant atmosphere at the centres. A user was very conscious of what he had gained from being in the pilot project:

More confidence, and getting out more. Otherwise, I was just sitting at home in my flat on the sofa, just watching the TV; and sleeping and waking up, sleeping, waking up. I never came out or anything. Did not see other people. The project really has made me come out and open myself up. And I would say Sydvesten [name of the pilot project] is my second home.
In sum, then, for a great many of the users—in general the most heavily effected—the drop-in centres constituted an important spatial framework in which respectful and non-stigmatizing interaction could take place, where they could socialize, and where they could obtain informal counselling.

Conclusion

The focus of the article has been on users’ positive experiences of enhanced psychosocial methadone maintenance treatment. I have argued that while the ideological importance of the user/consumer has grown throughout contemporary society, the voice of drug-treatment users is still almost unheard. This is also reflected in treatment research and evaluation, where one often only centres on treatment outcomes. This situation is not satisfactory, because hearing what drug-treatment users say can allow us to formulate more morally sound and maybe more effective drug treatment programs, as well as initiating a more subtle discussion of the criteria for effectiveness. In this paper I have argued for an open-ended research strategy in order to capture experiences, which go beyond an initial research focus. By doing so, I found that drug-treatment users value the form of treatment as much as the actual content. Our data show that for drug-treatment users no services stand out as superior; instead the context of treatment delivery is highlighted. In order to understand such experiences, I presented an analytical framework, and argued that drug-treatment users’ positive experiences of psychosocial methadone maintenance treatment can be captured by focusing on the attitude of the staff, time and availability, and, finally, spatial arrangements. In relation to the attitude of the staff the informants highlighted respectful interaction, being taken seriously, the case managers’ ability to ‘decode’ users’ problems, and, finally, the professionalism of the staff. With respect to time and availability the users drew attention to the availability of spontaneous counselling, the accessibility of practical help, and the importance of simply knowing that help is attainable. Finally, in relation to spatial arrangements, the users emphasized the value of a place where one feels welcome and safe, which could facilitate informal contact to counsellors (as well as other users), and which could alleviate one’s loneliness. It is my contention that the establishment of such a framework can enable us to outline a structural arrangement for methadone maintenance treatment, which would enjoy large user support.

On the basis of this conclusion I will make the following general recommendations for psychosocial methadone maintenance treatment of the most extremely affected drug user:

- Some kind of case management should constitute the basis for the treatment.
- A high level of availability for spontaneous counselling should be offered.
- The client–counsellor ratio should not be more than 1–20.
- Drop-in centres should constitute a part of the treatment.
Users with supplementary use of illegal drugs should not be excluded from the treatment.
Dispensing of methadone and the psychosocial treatment supplement each other when combined under the same roof and, furthermore, the medical part of the psychosocial methadone maintenance treatment (what Dahl, 2007, has referred to as ‘the methadone game’) should only take up limited space in the relation between the users and the counsellors.
Finally, user participation should ensure that the users can influence their treatment in important ways.

In a recent study from Scotland (McKeganey, Morris, Neale, & Robertson, 2004), which also applies a user perspective, we learn that drug users’ aspirations for treatment centre on the goal of abstinence and not harm-reduction changes, even though harm reduction has become a dominant perspective in treatment. Though I do not dispute these findings and though clients often do have a general and overall ambition of abstinence, in the actual day-to-day treatment process they also have many minor but nonetheless important aspirations. The frameworks I have presented—time, space and attitude—can in this regard be seen as providing a more contextualized and nuanced perspective on some of the elements of harm reduction, which in the McKeganey et al. study were reduced and limited to ‘reduced drug use’, ‘stabilization’, and ‘safer drug use’ (for a similar contextualization see Koester et al., 1999).

Extending the findings of my article and the general recommendations made, one finds parallels in the literature evaluating the effect of psychosocial methadone maintenance treatment as well as case management from the client perspective. These studies also find that clients primarily stressed the importance of the following elements:

- A positive and trusting relation with the social worker.
- Being able to influence one’s own treatment plan.
- The professionalism of the social worker—that the social worker was accessible and willing to listen in a non-patronizing way.
- That the physical environment was comfortable and relaxed.

In general, clients stressed the form of the treatment (see, for example, Åberg et al., 2001; Bacchus et al., 1999; Brun & Rapp, 2001; Conners & Franklin, 2000; Lilly et al., 2000; Neale, 1998).

Case management and psychosocial methadone maintenance treatment are not unambiguous and uniform interventions [3] although at times they are represented as such (see, for example, McLellan, Arndt, Metzger, Woody, & O’Brian, 1993). The practices and services related to the different interventions vary from place to place. Also in the Danish Methadone Project we saw that the different subprojects interpreted psychosocial treatment somewhat differently, reflected in the variety of different treatment services offered, and differences in the weight or value of these services. In this article I have argued, that as much as one focuses on defining and refining the services...
related to psychosocial methadone maintenance treatment one should focus on the context or framework of the ‘treatment delivery’. Often an overly medical or rationalistic focus on psychosocial methadone maintenance treatment tends to overlook such a context: in short, it overlooks the fact that the framework or context of the treatment is as important as the content of the actual services. These insights can only be arrived at by applying a user perspective in treatment research.

Notes

[1] Case management is not a solid and well defined method. However, a survey of relevant literature shows the existence of six core elements: assessment, intervention, co-ordination, planning, monitoring, and evaluation (Graham & Timney, 1995; Moxley, 1989; Ridgely & Willenbring, 1992; Vanderplasschen, 2004). When I term the form of case management applied in the project as ‘loose’, it is because the four projects only rather sparsely operated with elements of monitoring and evaluation.

[2] There was, however, a dilemma attached to the users’ use of the drop-in centres. At the same time as the centres functioned as shelters of a kind protecting the users from the street life, this very street life was also imported into the centres by the users, as for instance when they talked about drugs, dealt drugs, paid debts, and so on (for similar observation see Grytnes, 2004). I mention these dilemmas in order to show that even though many users evaluated the methadone maintenance projects positively, dilemmas and negative experiences were also attached to the programmes. The focus of this paper, however, is the users’ positive evaluations.


References


