FINDINGS Druglink page for August/September 2012

HAS METHADONE BEEN REHABILITATED?

Having previously featured residential rehabilitation, now we turn to the opposite treatment pole – prescribing opiate-type medications to opiate addicts on a long-term 'maintenance' basis. Both act as a focus for political and professional controversy, poles to which differing and often opposing treatment philosophies pin their colours. The divisions were reflected in the policies of parties contesting the May 2010 election, from the Greens who wanted more heroin prescribing to the Conservatives, for whom methadone was "drug dependency courtesy of the state". Labour responded to this criticism, but without abandoning the mass methadone programme which it believed had cut crime and curbed infectious disease. Labour responded to criticism, but without abandoning the mass methadone programme which it believed had cut crime and curbed infectious disease. Dismayed by attacks on methadone, in April 2010, 41 British and international experts came together to defend "this life-saving treatment", an unprecedented alliance which shows how seriously they took moves to curtail it.

In the event, the national drug strategy of the Conservative/Liberal Democrat coalition which took power rowed back from pre-election rhetoric, offering sometimes contradictory sentiments from which both poles of the treatment debate could find comfort. One short, key sentence brought substitute prescribing in from the cold and under the umbrella of 'recovery', a safer political haven. But at the same time the strategy heralded a determined attempt (for most but not all patients) to eliminate the distinguishing feature of 'maintenance' prescribing – its indefinite and often long-term nature, downgrading it to a phase preparatory to "full" recovery rather than a complete recovery option in itself. Picking up the baton, the 2010–11 annual plan from England's National Treatment Agency for Substance Misuse heralded the end of maintenance prescribing for all but a minority of patients. The bulk would be offered "a time-limited intervention that stabilises them as part of a process of recovery, not as an end in itself". The agency recognised this would be a "radical reform" with risks evident in several studies, notably a US experiment (Source study 1) which allocated patients at random to either minimal-support methadone maintenance or enriched-support but more time-limited detoxification. Despite extra support, maintenance saved lives at relatively low cost.

Debates came to a head when in 2012 an expert group convened for the UK Department of Health by the National Treatment Agency for Substance Misuse delivered its guidance (Source study 2) for the drug treatment field on how methadone and other medications can more fully aid recovery from addiction. The report sought to reconcile competing perspectives, facing forward to show these treatments can be part of the new recovery agenda, despite that agenda's associations in some quarters with abstinence from all drugs including legal substitutes (no methadone) and with leaving treatment (no or curtailed maintenance). At the same time it faced backward to protect previously accepted views critiqued and threatened by this agenda: acceptance of the need for long-term and even indefinite prescribing in the face of the tenacity of heroin addiction and the vulnerabilities of its sufferers; the legitimacy in recovery terms of staying in as well as leaving treatment; and the value of harm reduction objectives and achievements short of the abstinence ideal. Its insistence that within the law and ethical practice, the nature and duration of treatment are matters to be decided between clinician and patient, not dictated by commissioners or national policy, continues the tradition most notably established by the 1926 Rolleston report (Source study 3), which protected the privileged doctor-patient relationship in the treatment of addiction from encroachment by penal drug control regulations.

On the ground, oral methadone is the workhorse, buprenorphine is behind but catching up, while injectable methadone and heroin now play a minor role. The UK arrived at this point after decades when it alone permitted heroin for the treatment of heroin addiction, resting on freedoms afforded doctors and patients by the Rolleston report. Having restricted heroin prescribing to a few hundred specialists, in the 1970s Britain moved decisively to the more 'normalising' oral methadone regimens pioneered in the USA (Source study 4). A long-acting drug taken orally just once a day and lacking in this form the euphoric impact of heroin injection, ideally methadone divorces addicts from the roller-coaster of injecting several times a day and from the need to devote their lives to financing and using drugs, with all its detrimental impacts on the addicts and on society. From the mid-'90s, mainland European countries trialled (Source study 5) and then adopted the heroin prescribing option the UK had largely abandoned, adding supervised consumption to the regimen, an approach which cycled back to Britain via the RIOTT trial (Source study 6) with similar results: for these seemingly intractable patients, heroin worked better than methadone but a surprising number did well when methadone was tried again in more optimal form.

Arousing visceral opposition and passionate defence, prescribing opiate-type drugs to opiate addicts for as long as needed on the discretion of the doctor treating the patient has for decades been the mainstay of heroin addiction treatment in Britain. Because opposing camps value different things, evidence alone will not decide whether it stays that way, but research does reveal what patients and the rest of us stand to lose or gain from a change in policy.

The references offered in this introduction are just a few of the analyses available on the Findings site. To help you narrow in on your main interests we offer three custom-made searches which retrieve all relevant analyses:
- Run this search for UK-based reports and studies.
- Run this search for relevant studies from other countries.
- Run this search for what happens what happens when patients leave substitute prescribing programmes, including times when treatment has been curtailed for reasons other than the patient's wishes.

SOURCE STUDIES Click blue titles to download the Findings analysis

1 Methadone maintenance beats detoxification as cost-effective life saver

Masson C.L. *et al*. "Cost and cost-effectiveness of standard methadone maintenance treatment compared to enriched 180-day methadone detoxification." *Addiction*: 2004, 99, p. 718–726.

In San Francisco opiate addicts were randomly allocated to a year of methadone maintenance or to stabilisation and reduction plus extra therapy and aftercare. Despite the extras, maintained patients stayed far longer in treatment and used heroin less often. Resultant estimates were that maintenance as opposed to reduction would gain life-years at an extra cost of about $17,000 a year, well within the conventional $50,000 cost-effectiveness threshold.

2 Expert report seeks to rehabilitate methadone

Strang J. *et al*. Medications in recovery: re-orientating drug dependence treatment. [UK] National Treatment Agency for Substance Misuse, 2012.

On behalf of the UK government an expert group developed a clinical consensus on how prescribing-based treatment for heroin addiction can be made more recovery-oriented in line with national strategy. Their report could make the difference between a dramatic rowing back in patient numbers and permitted treatment durations, or a re-orientation which preserves both yet improves outcomes.

3 1926 Rolleston report defends patient-doctor freedoms

Report of the Departmental Committee on Morphine and Heroin Addiction. HMSO, 1926.

In British drug policy history, no document has more claim to the term 'classic' than the Rolleston report. Nearly 90 years later, Britain is revisiting its arguments over how much maintenance prescribing and would be needed if rehabilitation was given greater priority, and whether the duration of prescribing is to be left to the patient and doctor to decide or subject to local and national constraints in the name of 'recovery'.

4 Seminal US study substitutes oral methadone for roller-coaster heroin injections

Dole V.P., Nyswander M. "A medical treatment for diacetylmorphine (heroin) addiction: a clinical trial with methadone hydrochloride." *Journal of the*

American Medical Association: 1965, 193(8), p.646–650.

Methadone maintenance began in a New York hospital as a small-scale experiment. Even its originators doubted it could work when everything else had failed. The transformation it brought about in the first patients (who "went and got an ice cream" rather than 'score' heroin) can still be seen today.

5 Continental Europe transforms UK heroin prescribing tradition

Ashton M., Witton J. "Role reversal." *Drug and Alcohol Findings*: 2003, 9, p.16–23.

Detailed examination of the messages of heroin prescribing studies from the UK and continental Europe, where the treatment was transformed by strict rules requiring patients to inject or smoke their heroin at the clinics several times a day, eliminating the risk that it would be sold on the illicit market, but ensuring that legal heroin remained a minority option.

6 Continental-style heroin prescribing works too in Britain

Strang J, Metrebian N., Lintzeris N. *et al*. "Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial." *Lancet*: 2010, 375, p. 1885–1895.

Controversial and expensive it might be, but in the first British randomised trial, a continental-style heroin prescribing programme featuring on-site supervised consumption suppressed illegal heroin use much more effectively than oral methadone.