15.6 Stripped down methadone prescribing better than leaving patients to wait

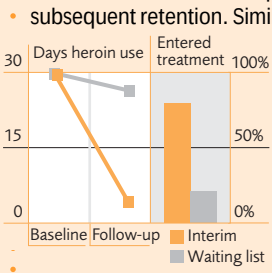
Findings Patients offered basic substitute prescribing while waiting to join a fully-fledged methadone programmmake far greater reductions in their heroin use, feel better, and are more likely eventually to enter the programme than patients simply left to wait.

As long as patients are waiting to enter a comprehensive programme, and every dose is supervised, US regulations excuse 'interim' methadone programmes from providing regular counselling for up to four months. For the first time a clinic in Baltimore trialed a regime embodying these regulations. Of 319 applicants waiting at least two weeks for its usual methadone programme, 199 were randomly allocated to interim prescribing from a nearby mobile facility. After a brief induction and medical examination, prescribing started the following day. Remaining patients were placed on the usual waiting list and had no further contact with the clinic until a place became available. All the patients were told how to apply to other local clinics.

The interim programme began with a dose of 20mg rising daily to an intended 80mg subject to individual adjustments. Though it entailed daily contact with clinic nurses, no counselling was provided except in a crisis or to consider patient requests to exceed 80mg. Only three patients sought and received such counselling.

Patients attended over 9 in 10 scheduled visits to the interim clinic and just 16% who started this treatment dropped out during the four months without transferring to an alternative programme. During this period, drug use overall (including drinking) fell significantly more among the interim patients. Whilst waiting-list patients continued to use heroin nearly every day, at follow-up (either on entry to a mainstream methadone programme or at the end of the four months) interim patients said they used on average just once a week, a drop confirmed by urine tests and reflected in dramatic reductions in spending on drugs and in illegal income not seen in the waiting-list patients. By the end of the four months, three quarters of the interim patients had started a fully fledged methadone programme (most at the study's clinic) compared to just a fifth of waiting-list patients *chart*.

In context None of the eligible patients refused to join the study, a sign of the attraction of the chance to gain immediate access to methadone. But as well as methadone, they were guaranteed a place in the main programme after four months if they had not found an alternative. This might partly account for why so many more were able to start fully-fledged treatment. However, the most relevant earlier study did not offer a guaranteed place yet still found that bridging the waiting period with a (more or less) methadone-only stop-gap cut heroin use in half compared to simply being placed on a waiting list. In this study, too, entry in to standard treatment was improved. It also found no adverse impacts on subsequent retention. Similarly, in Oslo a buprenorphine-only bridge for patients awaiting entry to the methadone programme cut drug use and improved well-being compared to a placebo and more patients completed the interim treatment, though eventual entry rates to the methadone programme seemed unaffected.



In one of the few direct tests of interim arrangements in the UK, a Scottish clinic overwhelmed by referrals introduced a programme which streamlined treatment entry and provided psychosocial support only when patients sought it. 60 of the 101 patients were discharged to further treatment but many preferred the less demanding regime, resulting in longer than expected stays. Whilst in the programme, patients reported dramatic reductions in injecting and decreases in crime and depression. Other British services have successfully tided patients over the waiting period through arrangements such as interim prescribing from GPs. Accelerating entry to methadone programmes is an alternative to interim care. US and UK studies have shown that this greatly increases treatment uptake without adversely affecting later retention or outcomes, exposing delays as a barrier to treatment, not a filter to exclude the unmotivated or unpromising.

Though the featured study concerned interim entry arrangements, others have trialed stripped-down methadone programmes as an alternative to more comprehensive provision. Selecting low-risk patients only, an English service replaced key-working with fortnightly drop-ins during which clients might be counselled by any member of the team. Capacity increased yet patients were satisfied with the service and well retained. Without such selection, and if the caseload is severely problematic and unstable, stripped-down regimes have proved untenable because crises demand repeated intervention. In these circumstances, despite costing less, cost-effectiveness in terms of £ per abstinent patient deteriorates. Whether extra services create substantial extra gains will depend partly on how well targeted and adequate those services are – little added value can be expected from adding irrelevant or poor provision. An alternative to a stripped-down programme is to allow patients to choose whether and when they want counselling. In Toronto this and other relaxations in the regime increased capacity without affecting retention or on-top drug use.

Practice implications Subject to sufficient assessment and monitoring to ensure clinical safety, starting prescribing without regular counselling or other psychosocial supports is preferable to simply leaving patients waiting, even for a few weeks. Patients reduce their drug use, health risks and criminal activity, and more go on to enter the main programme. For some patients, little more may be needed and such programmes can form a longer term alternative to more intensive support. These patients might be identified by how well they do in the interim programme. However, multiply problematic clients do benefit from regular counselling and well targeted ancillary services. Without these supports they suffer repeated crises, in the end demanding more intensive and expensive interventions. Cost-effectiveness is probably maximised by making more intensive and extensive services *available* for those who feel they need them, or where referral to such services seems advisable. NTA guidance defines the start of treatment as the date methadone is first dispensed, meaning that so long as care planning has occurred, interim arrangements such as those trialed in the featured study not only benefit the patients, but can help meet waiting list and intake targets.

LINKS
Nugget 1.4
Nuggettes 12.1 11.2

Featured studies Schwartz R.P. *et al*. "A randomized controlled trial of interim methadone maintenance." *Archives of General Psychiatry*: 2006, 63, p. 102–109.

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