DRUG & ALCOHOL FINDINGS

Has methadone been rehabilitated?

The use of substitute medications such as methadone in treatment for opiate dependency has always been controversial. But what does the clinical evidence say? **Mike Ashton** takes a look at where things currently stand...

Residential rehabilitation and 'maintenance' prescribing of opiate-type medications serve as poles to which antagonistic treatment philosophies pin their colours. Divisions were reflected by parties contesting the 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 it believed had cut crime and infectious disease.

In its national drug strategy, the Conservative-led coalition which took power rowed back from pre-election rhetoric, offering contradictory sentiments in which both poles could find comfort. A key sentence ("Medically-assisted recovery can, and does, happen") brought maintenance under the safer political umbrella of 'recovery'. But the strategy also heralded a determined attempt (for most, but not all patients) to eliminate what makes maintenance 'maintenance' – 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 NTA annual plan reframed methadone as "a time-limited intervention that stabilises [patients] as part of a process of recovery, not as an end in itself". The agency recognised this "radical reform" had risks, evident in a US experiment (Source study 1) which found that despite extra support offered to detoxification patients, maintenance saved more lives at relatively low cost.

Debates came to a head when, in 2012, an expert group convened for the Department of Health delivered its guidance (Source study 2) on how methadone and other medications can aid recovery. The report sought to reconcile competing perspectives, facing forward to show these treatments can be part of the recovery agenda, despite that agenda's associations with abstinence (no methadone) and leaving treatment (no or curtailed maintenance). At the same time it faced backward to preserve acceptance of the need for long-term and even indefinite prescribing, the legitimacy in recovery terms of staying in as well as leaving treatment, and the value of harm reduction gains short of abstinence. Its insistence that the nature and duration of treatment are to be decided between clinician and patient, not dictated by policy, continues the tradition established by the 1926 Rolleston report (Source study 3), which protected the privileged addict-patient relationship from encroachment by drug control regulations.

Today oral methadone is the workhorse and injectable methadone and heroin play a minor role. The UK arrived at this point after decades when it alone permitted heroin for the treatment of heroin addiction. Having restricted this 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). From the mid-'90s, mainland European countries adopted (Source study 5) the heroin prescribing option the UK had largely abandoned, adding supervised consumption, 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 at the discretion of the treating doctor 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.

Selected entries from the Drug and Alcohol Findings Effectiveness Bank project. For the full story with more information, citations and links visit: http://findings.org.uk/count/downloads/download.php?file=DL5.php

SOURCE STUDIES

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.

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.

3 1926 Rolleston report defends patient-doctor freedoms *Report of the Departmental Committee on Morphine and Heroin Addiction*. HMSO, 1926.

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.

5 Continental Europe transforms UK heroin prescribing tradition Ashton M., Witton J. "Role reversal." *Drug and Alcohol Findings:* 2003, 9, p.16–23.

6 Continental-style heroin prescribing works too in Britain Strang J. *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.