PRESCRIBE WITH CAUTION

Thirty five years treating alcohol and drug addiction have taught Dr Bewley caution and respect for research.

Thomas Bewley

PRESCRIBING OPIATES to people dependent on them has always been associated with some controversy. However, research[1] has shown that methadone can be an effective treatment when administered to chronic narcotic addicts who are actively addicted and living in an environment where narcotics are readily available. Outpatient methadone treatment can also be a stepping stone to permanent discontinuation of narcotic addiction and appears to provide control over some of the personal and social consequences of addiction, including criminal activity.[2]

Other studies have concluded that patients do well on any dose but those on high doses generally used fewer drugs and tended to do better.[3] It has also been shown that, while abstinence after narcotic dependence was possible, it was not always a realistic goal and premature detoxification could be associated with a high relapse rate.[4] Methadone can be used to treat those pregnant addicts who are unlikely to detoxify. Detoxification is not advised early or late in pregnancy.

A British study[5] conducted in the mid-70s concluded that prescribing oral methadone constituted a more confrontational response than prescribing injectable heroin, resulting in a higher abstinence rate but also a greater dependence on illegal sources for those continuing to inject.

Prescribing drugs of addiction to patients who are dependent on them can be an effective treatment, and is also acceptable medical practice in Britain, but such prescribing must always be done responsibly and in a carefully controlled way. In 1980 I recommended[6] the medical profession should consider whether there was any place for private treatment of addicts where a fee was contingent on a prescription. Since then several doctors have appeared before tribunals or been found guilty of serious professional misconduct.

In 1980 I also published guidelines for prescribing psychoactive drugs to addicts and suggested safeguards which I believe are valid today. In particular, the least required from a doctor prescribing opioids to an addict is that:

▶ A diagnosis of physical dependence has been made, confirmed by an appropriate history and physical examination. It is also desirable to arrange urine analysis to confirm which drugs have been used.

▶ Extra care should be taken with patients not already known to the doctor, particularly those treated privately or as a temporary resident.

▶ No treatment, apart from emergency treatment, should be given without first finding out what treatment the patient has had, or is having, from other doctors.

▶ If a patient attends a doctor privately the doctor must ensure they are coming for treatment and not solely to obtain drugs in return for the fee. Questions to be asked in such a case are:

— has the doctor special expertise in the treatment of drug dependence?

— has he proper facilities such as access to hospital services like urine analysis?

— is he providing treatment other than a prescription for a controlled drug?

— is he prescribing in such a way (eg, more 'liberally', larger amounts, prescribing drugs attractive to addicts and not otherwise available) that there is an inducement to addicts to attend privately?

— does he prescribe drugs such as amphetamines, for which there is little medical indication, for patients who might want them for non-medical reasons?

The current belief that doctors in NHS treatment clinics now have a treatment philosophy that all patients have to be detoxified from methadone within a short period, and that there is no place for long-term methadone treatment, may be due to a misunderstanding of the report of the Medical Working Group on Drug Dependence.[7] This stated that "the aim of treatment should be to help drug misusers to deal with problems related to their drug misuse and eventually to achieve a drug-free life". The important word here is *eventually*, as there is good evidence that many patients benefit from long-term treatment and do better than those prematurely detoxified.

However, long-term treatment is only appropriate when short-term treatment has been unsuccessful. Those who do well following detoxification immediately or after a short programme of methadone prescribing, cease to be among those who might need a continuing prescription. At the St. Thomas' Hospital's clinic in 1987, 40 per cent of patients with a prescription for methadone had received this for less than a year, but 25 per cent had been receiving it for seven years or more.

A new complication associated with opiate addiction is the spread of HIV between addicts. Needle exchange schemes have been proposed as a way of minimising the spread, based on the proposition that some addicts will inject themselves anyway, so it would be better if they were to do so with uncontaminated needles. There is no evidence at present that exchange schemes have this effect, nor is there any to suggest they make it easier and more acceptable for people to inject.

In this situation the DHSS decision to have a limited number of pilot projects appears the only sensible way forward. It now appears likely that a number of similar projects will be set up by other agencies keen to do something helpful. The relevant question is the extent to which the sharing of injection equipment can be reduced by providing free syringes and needles, beyond the reductions that have already occurred in response to the AIDS threat.[8]

Previous surveys[9] have shown that drug misusers do inject themselves in very unsterile ways and are more likely to do this while intoxicated or in withdrawal, when they may have a strong craving for an instant 'fix'. In these circumstances they are unlikely to postpone injection because of a lack of sterile needles, nor are they likely to boil them for long enough to ensure sterility. Immediate sterilisation (with bleach or some other way) is probably the method drug misusers would be most likely to practise.

The advantages and disadvantages of issuing syringes and needles are finely balanced. If one is endeavouring to encourage all patients to take drugs orally but they are simultaneously given needles and syringes, they might be more likely to inject themselves, contrary to the treatment philosophy. On the other hand, if they are injecting themselves, they might do this in a more hygienic way if they obtained sterile syringes and needles. There is no proven advantage either way.

THERE REMAINS a strong desire to be doing something positive to prevent the spread of the virus between addicts. The spirit is similar to that of physicians who 200 years ago treated tuberculosis with inhalations of garlic and blood-letting. This did nothing for the patients — in many instances was positively harmful — but the physicians needed to be 'doing something': it possibly made them feel better, if not their patients. In the same way needle exchange schemes currently appear to be very popular, because of the need to be doing something positive. More validated research is needed. □

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