Dr Colin Brewer

Princely patient provision

Methadone programme evaluation

From time to time all doctors ought to consider whether the treatment of a particular patient is as good as it should be

The system of treatment evaluation I have developed tests if the treatment of a patient is up to scratch and uses two simple measures:

- If this patient was the Queen would she be satisfied with the treatment I am providing and the way that I am providing it?
- Would at least some respected figures in addiction medicine agree with my choice of treatment?

In other words, I consider the quality of the doctor/patient relationship and the quality of the treatment – though not necessarily with that priority.

It would probably be over-egging this hypothetical pudding to ask you to imagine that the Queen has recently become a heroin addict. At 70, she would be a bit old for that sort of thing.

There is a family history of drug use. Queen Victoria became quite fond of cocaine in the form of Mariani's wine (a sort of high-octane Sanatogen) marketed towards the end of her long and glorious reign. Victoria may also have been familiar with laudanum and other opium based medicines, which were popular during the early part of the last century.

Our present Queen's grandchildren are part of a drug-using generation and, as we are repeatedly told, drug users come from all classes of society. So it is not too hard to imagine a royal scion turning to heroin. They certainly have a few friends who don't exactly stick to fizzy water.

Vulnerability

Some say stress is an important factor in addiction, others that addicts use illicit drugs to self-medicate underlying psychiatric illness. Fashion, adolescent experimentation, peer-pressure, genetics and availability are also important factors. Poor mad George III has been dead for a while, but on all these counts the royal family could be said to be vulnerable.

Let us assume that one of the young royals – we shall call him Prince Rupert – started using illicit drugs, eventually got himself a heroin habit and now, aged 28, wants to go on to maintenance with methadone (or morphine or buprenorphine). Fortunately, he doesn't inject.

At this point, I offer you a choice of scenario. Either, the princeling has already been to all the smart rehabilitation centres in Britain, with all the attendant publicity, but hasn't stayed clean for long (he wouldn't be so unpatriotic as to go to America for rehab). Or, he wants to avoid the rehabs and the publicity and thinks that a period on methadone might be a good start.

He might even share Alan Bennett's view of Twelve-Step groups, as recounted in his best-selling diaries. 'People were getting up and saying "Hello, my name is Fred and I'm an

Dr Colin Brewer
is the Medical Director at the Stapleford Centre, London

alcoholic." After a while, I wanted to get up and say "Hello, my name's Alan. I'm English and we don't do this sort of thing here."'

Rupert is a modern royal and has a job, which he likes and is anxious to keep. That's another reason why he might not want to go back into rehab. His girlfriend, Clarissa, isn't much of an illicit drug-user apart from an occasional joint and she can enjoy a few glasses of wine without becoming objectionable. She's happy to keep an eye on his methadone and to let me know if he is continuing to use heroin. The hair tests I shall want from Rupert at regular intervals will tell me that anyway, if a little less promptly.

As an experienced addict Rupert has had methadone before, though never on prescription or a proper maintenance course. From experience, he thinks he needs about 150mg. He's 1.93m (6' 4") tall and weighs about 100kg (220lbs or 15 stone 10lbs), so 150mg is not a particularly high dose. I give him 110mg for starters and 1½ hours later he is still wide-awake.

Any old medicine

I feel I can trust Clarissa, especially as she is willing to have a hair test herself to show she isn't likely to sample his methadone. Even so, I ask him to swallow his first two or three doses under supervision, by arrangement with a discreet pharmacist. This is because, on the basis of the test-dose, I prescribe 150mg daily, and I think it does no harm to remind even a Prince that although 'methadone is medicine' (to quote a slogan I saw at an American meeting) it is not just any old medicine.

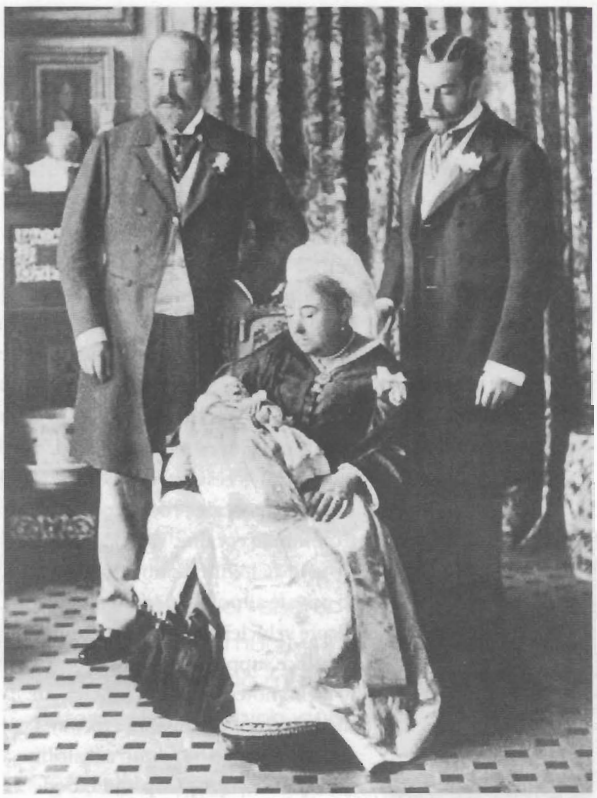
I see him again after a few days and at intervals increasing to about once a month thereafter.

He has already been counselled almost to death and doesn't want (or need) to go over the ground again. They know that if unexpected problems occur either of them can get in touch with me quickly. Both of them confide in Clarissa's much-loved Aunt Fiona, a jolly country solicitor, who also keeps me posted.

Rupert usually collects a week's supply of methadone at a time. When his job takes him abroad, which it often does, he may need to pick up three or four weeks' supply. For the same reason, and also because he has never injected, I prescribe methadone tablets: they are less bulky, less conspicuous and can't leak all over his Jermyn Street shirts.

I think it very unlikely that he would 'pig out' on methadone or sell it to other addicts. He wants to try to minimise contact with the demi-monde of illicit drugs and is trying to develop an alternative set of friends. For the moment, he just wants to let the dust settle and take a break from detox, which leaves him depressed, irritable and sleepless for months.

After a month or two, his hair tests are negative for opiates and other problematic drugs and largely stay that way. When the time is right, he will probably decide to detox quickly and relatively comfortably under sedation and transfer to naltrexone. I will tell Clarissa how to supervise it properly.



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Fairy tale?

Although I have described a programme fit for an imaginary prince, there are many people suitable for methadone treatments who have similar drug-using careers and who also have busy and responsible jobs.

One real example is Bill Nelles, now general secretary of the Methadone Alliance but until recently a senior manager in the NHS. Even if their origins are less elevated, they too need prescribing arrangements appropriate to their work.

Flexibility in treatment is generally considered a 'good thing' in most areas of medicine. But there seem to be those who want to make it difficult for me to initiate and continue methadone treatment in the way that I have just described. The new guidelines suggest that everyone should collect their medication and drink it under supervision daily for the first three months. Methadone tablets are strongly discouraged.

This policy would interfere considerably with the jobs of people who often struggle to keep or find employment. It can also double or triple the cost of public or private methadone through daily 'controlled drug' and dispensing fees. It puts opiates at or near the centre of addicts' lives when I try to make the drugs increasingly peripheral and unimportant.

Not all patients merit the degree of flexibility and trust that might be appropriate here, but how can trust be earned if it is never given? Even in the United States, where rigidly supervised methadone programmes are the rule, for some time now it has been possible for selected, stable patients to pick up a month's supply of methadone tablets and very few abuse the system.

It would be ironic if the new guidelines force us down a US one-way street, just when they are beginning to see the virtues of the humane, flexible and user-friendly British road ■