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▶ A survey of community drug team prescribing policies and client views.

Luty J., O'Gara C., Sessay M. et al.

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Contrary to national guidelines, in the mid-2000s in England and Wales, prescribed doses of the heroin substitute methadone were generally low, and often even new patients were not required to take it under supervision at the pharmacy. Patients in Essex also generally favoured low doses and opposed supervised consumption.

Summary Based on data from the mid-2000s, this report relates the findings of a survey of usual prescribing practices at NHS community drug teams in England and Wales (which treat addiction to drugs including heroin) to a companion survey of the opinions on these policies of patients from one area.

Prescribing practices

In 2004 and 2005 a postal questionnaire was sent to the prescribing doctor at each of the 140 community drug teams in England and Wales, supplemented by phone calls to team managers to determine further details of their prescribing practices and policies. Responses were received from 120 of the teams.

All but 3% of the services which responded could arrange supervised consumption of methadone either through an on-site dispensary or at local pharmacies. However, 22% of teams said fewer than half the methadone patients starting treatment were supervised. In 45% of teams fewer than 10 patients were on methadone doses exceeding 60mg a day. All but 3% of teams prescribed buprenorphine to opiate-dependent patients. Six in ten prescribed benzodiazepines only for alcohol detoxification. One in four would prescribe these drugs on a maintenance basis, though only four teams did so for more than 10 patients. Injectable medications had been prescribed by 24% of teams, but only two had over 10 patients on these formulations.

Patients' views

At the time the drug and alcohol services of the South Essex Partnership NHS Trust treated about 1300 patients at four community drug teams in South East England, of whom about 600 were prescribed methadone or buprenorphine. Over half the methadone patients received doses between 30 and 60mg a day and fewer than 10 over 80mg. Over 9 in 10 initiated methadone treatment on supervised consumption for at least three months.

The views of the patients on prescribing policies in general (not at their particular service) were assessed in 2005 via questionnaires offered by receptionists and prescribing doctors to all patients being prescribed methadone or buprenorphine. 104 responded. About three quarters were men, 15% were employed, and nearly 9 in 10 had left full-time education aged 16 or younger.

Asked "What do you think is the maximum dose of oral methadone that should be prescribed to people who are addicted to heroin?", just 10% thought there should be no limit; most (53%) opted for a limit of up to either 60mg or 80mg. They were told that UK guidelines recommended methadone "should be taken in front of a pharmacist each weekday for at least 3–6 months" and asked if they agreed; 52% disagreed, 34% agreed. Two thirds said benzodiazepines should only be prescribed as part of a reducing regimen and then only with daily collection.

The authors' conclusions

Relatively low doses of methadone remain the norm in England and Wales and contrary to national guidance, a sizable minority of clients were still started on methadone to take away. Buprenorphine was almost universally available. Community drug teams were reluctant to prescribe injectables or to offer benzodiazepines other than for alcohol withdrawal. Patients in opiate substitution treatment in Essex were generally opposed to supervised consumption of methadone, but otherwise tended to support rather conservative prescribing policies. More below.

Despite guidelines to the contrary, and the dangers of diverted methadone, a fifth of patients started on methadone are prescribed it to take away, and the proportion is likely to be much higher among long-term patients. Recently the same authors had phoned 1000 pharmacies throughout England and discovered that two-thirds of patients were prescribed methadone to take away. Historical practice and the reluctance of many British pharmacies to provide the required facilities make routine supervised consumption of methadone difficult to provide. Since just over half the service users asked were opposed to supervised consumption, community drug teams may also be under pressure from service users to permit methadone to be dispensed to take away.

A potential compromise is to prescribe lower doses so methadone can more safely be taken away. Nationally about half community drug teams had fewer than 10 patients on doses over 60mg methadone daily. Low dosing is supported by service users in Essex, just over half of whom said doses should not exceed 80mg. There are persistent concerns that doses in the UK are suboptimal for the patients. On the other hand, higher doses create a potentially serious risk to other drug users when sold on the black market. Other reasons for low doses might be a preference for detoxification rather than maintenance; at a London clinic, asked whether outpatient detoxification or maintenance was most

likely to stop them using street heroin, 60% of patients opted for detoxification, contrary to evidence from research. Low doses may also be due to the number of inexperienced doctors in addiction treatment, or the experience of many workers that modest doses of methadone (up to 60mg) do prevent illicit opiate use in many clients. Patients themselves do not agree with the prescription of very high doses of methadone, so there may be little demand from them for these levels.

The reluctance of community drug teams to prescribe benzodiazepines on a maintenance basis was supported by the patients in the survey, as was caution over prescribing injectables.

In interpreting these findings it should be remembered that patients self-selected whether to complete the survey; about 1 in 6 of all those prescribed methadone or buprenorphine at the four clinics did so.

FINDINGS The persistence of unsupervised methadone prescribing in England and Wales (less so in Scotland) is unusual internationally and is also where the preferences of patients (generally against) and national guidance (in favour at the start of treatment) most obviously diverge. The approach has yet to be subject to large scale research in Britain. This was one of the intentions of the NTORS study of addiction treatment in England which recruited its patients in 1995. The closest the study came to reporting the findings was a comparison between seven GP-led methadone services and eight specialist clinics. The major difference in their prescribing practices was that three quarters of the clinics required patients to take their methadone under supervision, but just one of the GP programmes. Two years after entering treatment, GP and clinic patients had improved substantially and to roughly the same degree, but what differences there were favoured the GPs. GP patients had made significantly greater reductions in use of stimulants and non-prescribed benzodiazepines and greater gains in psychological health. They also tended to stay in treatment longer.

Additionally, a small scale Scottish study randomly allocated 60 patients to supervised consumption. However, all had already been in supervised treatment for about three months so the relaxation did not breach guidelines. For the next three months they either stopped being supervised (but still had to collect their medication daily) or were supervised daily or twice weekly. Unsupervised patients were most likely to stay in treatment, those supervised daily to leave. Among the 46 who could be reassessed, illicit heroin use was rare before the switch (one or two days a month) and remained rare at the end, though with slight reductions among the supervised patients and a slight increase among the unsupervised. None of these differences between outcomes under the three supervision regimens were substantial or statistically significant. There was however a clear divide in patient reactions. Two-thirds of those relieved of the need to take their medication at the pharmacy were happy about their allocation, but only 30% subject to twice-weekly supervision and 14% daily. Given the chance to express their views in their own words, the unsupervised patients highlighted reduced stigma, the supervised patients, the continued stigma of being exposed as a methadone patient at the pharmacy.

An important reason for supervising consumption is to prevent methadone being sold on the illicit market or otherwise 'diverted' to people other than the patient for whom it was intended, with possibly fatal consequences in the form of opioid overdose. A study of

methadone overdoses in Scotland and England suggests these concerns are valid and that supervision does have the desired impact. It concluded that declines in the per-dose rate of deaths due to methadone overdose were due to the spread of supervised consumption, the main reason for a remarkable improvement in the safety of methadone prescribing from 1995 to 2004. However, the study was unable to determine whether each opiate user in or out of treatment had become more or less likely to survive as a result of the introduction of supervised consumption. Supervision should also help prevent elevated death rates in the first few weeks of treatment because clinicians can monitor the patients more closely and directly control their methadone intake. It also means the prescriber can be sure that the drug has been taken and that therefore the patient has built up the required tolerance to make such doses safe, and helps assess whether higher doses are required and would be safe. The structure and contact it imposes can also be therapeutic.

Set against this, to the degree that (as some clinicians believe) the supervision requirement causes dependent opiate users to avoid treatment it would prevent substitute prescribing realising its lifesaving potential. As suggested by the Scottish study referred to above, some studies have also reported that patients find it difficult to comply with long-term attendance or supervision requirements, leading to reduced compliance with treatment and premature drop-out or discharge, impacts which would again reduce the treatment's benefits via reduced retention. How these contrary influences balance out to affect overdose on opiate-type drugs as a whole − heroin as well as methadone − is unclear.

For a similar but later survey of services in Scotland see this Findings analysis. For a summary of research on these and related issues see this Findings review. Other analyses related to supervised consumption can be found by running this search.

Thanks for their comments on this entry in draft to Andrew Byrne of The Byrne Surgery in Sydney, Australia. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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