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INSTITUTE OF GENERAL PRACTICE  
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# The Evidence for Methadone Maintenance Treatment, Legal Issues and Ethics



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# D.O.H. Guidelines for Treatment of Drug Dependence (1999) (1)

“The evidence base for methadone treatment is now unassailable”

- 30 years of experience
- 20+ years of studies



# What Can Methadone Maintenance Treatment Achieve

- For a complete summary of the evidence over 20 years, see (2)
- A dramatic reduction in mortality among heroin users (3,4)
- Reductions in transmission of blood-borne viruses (7,8)
- Improvements in health and social functioning (9)
- Reductions in crime of more than 50% (5,6)

**NB social consequences of this for the individual and family**



# The Impact of Drug Use on Crime

NTORS Study(5) 1,110 patients had committed over 70,000 crimes in the past 3 months

- ◆ In the past 2 years, costs to the criminal justice system (excluding prison) of sentencing these patients was £4 million
- ◆ In the past 2 years, costs to the victims of these patients was £34 million
- ◆ Task Force Study showed 9/10 young drug users had been involved in crime
- ◆ Sheffield Pilot Study (6) showed 52 out of 57 patients had criminal convictions



# Does Treatment Affect Crime Rates?

-Best evidence is for methadone treatment

- Parker and Kirby 1996 (10) Methadone Maintenance and Crime Reduction on Merseyside.
  - ◆ Property crime stopped rising
  - ◆ Other types of crime continued to rise
- CALDATA (California Drug and Alcohol Treatment Assessment) (11)
  - ◆ Cost benefit averages seven dollars return for every dollar invested in treatment
  - ◆ The largest savings were due to reductions in crime
- Dole and Joseph (12) 1969 New York
  - ◆ Stringent criteria
  - ◆ Control group 53 times more likely to have been reincarcerated at 1 year than treatment group



# Settings

The effectiveness of methadone treatment has been shown in various settings, including

- Specialist clinics (4)
- GP surgeries (13)
- "Specialised" GP schemes (14)

Involvement of community pharmacists now building up on evidence base for feasibility and acceptability (14,15)



# How Can We Optimise Methadone Maintenance Treatment?

- Retention in treatment is an important indicator of long term outcome (16)
- Higher doses of methadone are more effective in keeping patients in treatment, decreasing illicit drug use and reducing crime (17,18)
- Large amounts of support to methadone maintained clients are not cost-effective but moderate amounts of support are better than minimal amounts (19)

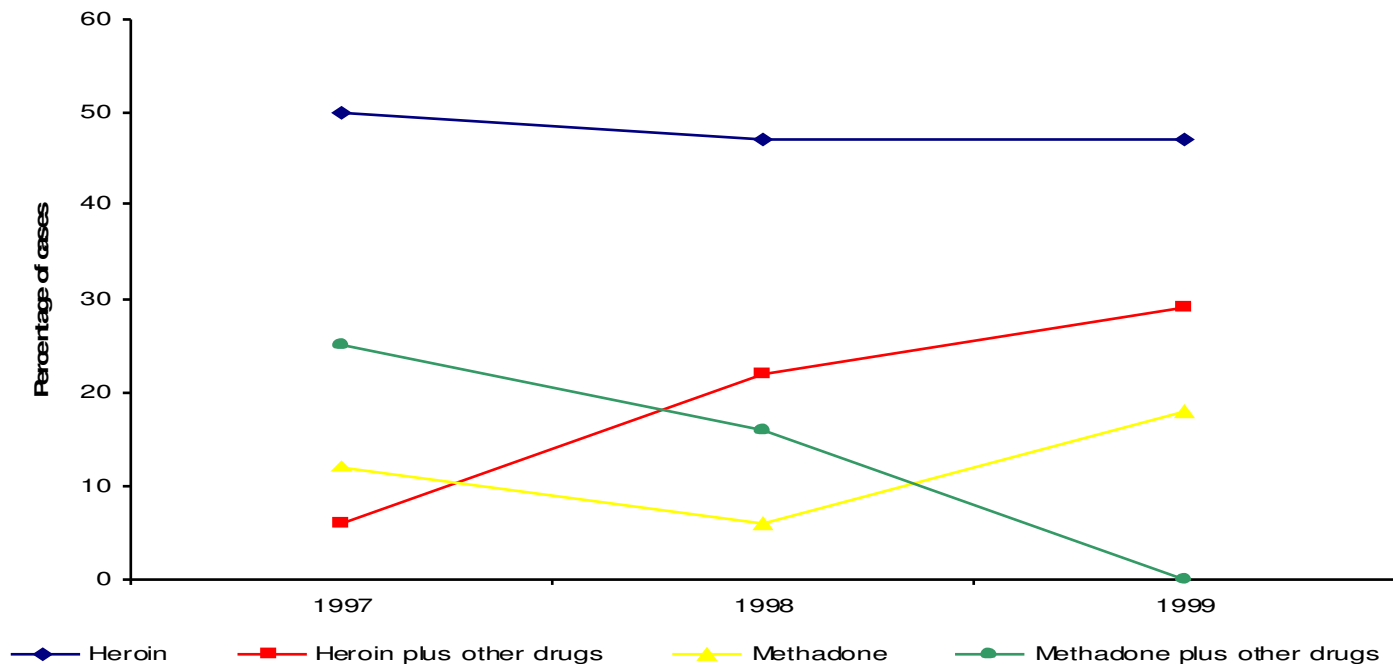


# Does Methadone Itself Cause Deaths?

- Conflicting evidence depending on how methadone is prescribed and dispensed
- Methadone sometimes found at post mortem amongst other drugs
- Heroin users are a high risk group
- Injectable methadone more risky
- Methadone especially risky in combination with alcohol and benzodiazepines
- On balance methadone saves vastly more lives than it puts at risk but safe dispensing is key

# Involvement of Methadone

Figure 5 – Proportion of cases in which heroin, heroin plus other drugs, methadone and methadone plus other drugs were considered the cause of death for 1997, 1998 and 1999.



**Methadone at post mortem 1997 – 35%**  
**1999 – 15%**

**Heroin at post mortem 1997 – 55%**  
**1999 – 80%**



# Ethical and Legal Aspects of Methadone Prescribing

- National Guidelines (1) provide a basis for the modern approach to ethical and legal issues
- Based on a recognition of the excellent evidence base for methadone treatment
- Attempt to look at rights of patients and responsibilities of doctors



# Legal Status of Guidelines

- Guidelines 1999:

" A significant reference point in assisting the G.M.C. in its power to examine reports of alleged poor performance by medical practitioners."

- Tackling Drugs to build a better Britain  
D.O.H. 1999: (20)

" dispensing of clinical services in general [should be] in line with forthcoming D.O.H. Clinical Guidelines"



# Key Ethical Principles of New Guidelines

- 1 The entitlement of drug users to receive the same level of service as other patients.
- 2 The responsibility of all doctors to address drug-related problems and prevention of harm.



# 1. Rights of Drug Users

- Some NHS entitlement as other patients (good G.M.S. from a GP)
- Not an automatic right to substitute prescribing  
**BUT**
  - ◆ High quality harm minimisation advice from all doctors
  - ◆ Good assessment and appropriate referral by GP
  - ◆ Testing and Vaccination where appropriate

NB Guidelines quote the G.M.C.

“the rights of all patients to receive high quality care, irrespective of their medical condition”



# Practical Implications of Rights of Drug Users:

- Doctors can no longer hide behind lack of training
- Patients can expect all doctors to be well-informed about drug-related problems.
- All GPs should provide the basics, i.e.
  - harm minimisation
  - vaccination
  - referral
- Many GPs should provide prescribing within shared care
  - BUT**
- Support services and training should be provided for doctors



## 2. Responsibilities of GPs

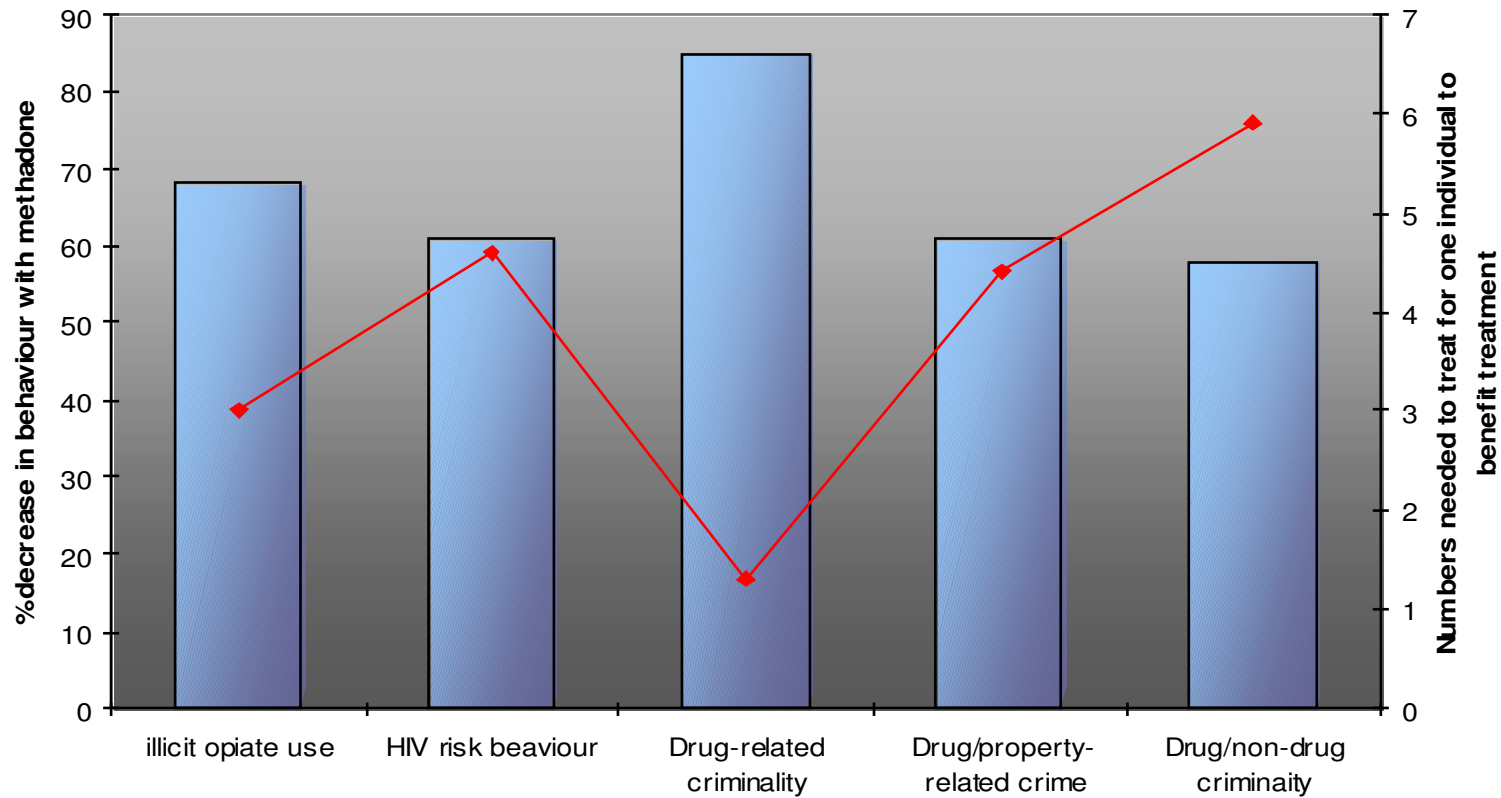
- Patients should not receive inferior treatment simply because their doctors perceive the pathology as self-inflicted (quote from G.M.C.)
- **Methadone treatment saves lives**

How many treatments with such a good evidence base  
Are routinely denied to patients? (21)

# Meta-Analysis

## *Reported Bandolier 1999*

The Efficacy of methadone maintenance intervention in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis. (Marsh, L.A. (1998) *Addiction*. 93:515-32)





# Summary

- The evidence base for methadone is now unassailable
- The National Guidelines build on the evidence base for their ethical and legal structure
- Treatment in primary care is encouraged within a shared care framework
- Adhere to National Guidelines provides protection for the public against 'maverick' prescribing
- GPs need to be familiar with the guidelines and to be able to justify deviating from them
- Clinical practice falling within the guidelines should be defensible as such



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