

## LETTER TO THE EDITOR

# A six-year evaluation of methadone prescribing practices at a substance misuse treatment centre in the UK

To the Editor:

Dickinson *et al.* (1) recently assessed the impact on prescribing practices of the 1999 UK Guidelines on Methadone (2). The authors conclude that the guidelines ‘...have had a measurable and beneficial effect...’ Alas, this seems to greatly overstate the case.

Regarding starting dose, almost half (47%) of patients received 40 mg or more after the guidelines were published; of course, it’s the ‘or more’ that is particularly troubling. The guidelines were explicit (page 45): ‘Deaths have occurred following the commencement of a daily dose of 40 mg methadone. In general, the initial daily dose will be in the range of 10–40 mg.’ The persistent widespread use of dosages that are known to put the new patient at risk of death is difficult to comprehend.

At the other end of the spectrum are the maintenance doses. Again, the guidelines (p. 54) are clear: ‘...there is a consistent finding of greater benefit from maintaining individuals on a daily dose between 60 and 120 mg.’ As long ago as 1993, the then-Director of the US National Institute on Drug Abuse observed that ‘...in this age of AIDS, a low dose policy is not only inappropriate – it can be fatal...’ (3) And yet, in the UK clinic that is the focus of this article the average dose went down quite substantially, from 59 mg before September 1999 to 45 mg subsequently. It would appear that patients’ lives were endangered (and almost certainly some were lost) as a result of a change diametrically opposite to that which the guidelines urged. The authors’ explanation is devastating, all the more because it is probably spot on: ‘...general practitioners may have other philosophical, psychological or moral (rather than pharmacological and clinical) reasons for prescribing inadequate doses.’ How could one possibly explain to a parent, child, or partner of a patient who has died of a heroin overdose that the guidelines were ignored and adequate dosage withheld because the physician allowed ‘philosophical, psychological or moral’ objections to

take precedence over pharmacological and clinical considerations?

Physicians and their associated staff in the clinic studied (and almost surely in many others as well) should be reminded of their obligation to provide the very best evidence-based care to their patients. Heeding the recommendations of the most experienced authorities in the field would be a good place to start.

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## REFERENCES

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## RESPONSE FROM AUTHORS

Sir,

Although Robert Newman’s letter regarding our study was critical, we are at least pleased that our work has been read by a very eminent pioneer of methadone treatment. We would emphasize that the main aim of our study was to monitor the impact of the 1999 Department of Health Guidelines on prescribing to drug misusers with the aid

of a convenient database, and we are not apologists for the typical UK treatment model. Indeed, one of the clinician authors has written extensively on the difficulties in providing methadone treatment adequately in the prevailing political climate, which involves patients in decisions about their dosing (4).

Many differences of opinion are about maintenance doses, and on the face of it, it looks poor that the average methadone dose prescribed by the Sheffield service has actually declined. Again the clinicians in our team feel there are two obvious factors at work: first, that as heroin use has become increasingly widespread and services more 'low-threshold' many individuals are encountered who only use small amounts of weak heroin, i.e. a somewhat different population from those in the early and dose-finding methadone studies. Second, is the 'partnership with patients' agenda which is extremely strong in the UK. Our clinicians find it a matter of absolute routine that they are trying to persuade patients to take higher maintenance doses than they agree to, with the users often still taking some additional drugs and having one eye on planning to be off methadone in due course. One of the best descriptions of this conflict in the literature still remains a report of a visit by another eminent methadone pioneer, John Ball, to a Dutch clinic more along UK lines. In it, Dr Ball describes how the typical patient they saw 'surprisingly...seems uninformed about the pharmacology of methadone maintenance' (2). It is no secret to say that clinicians here would like to be able to impose higher doses more than is currently considered acceptable. Indeed, some patients may need higher doses because of individual differences in metabolism (3).

Even the correct starting doses of methadone can be argued both ways, with risks inherent in giving

manifestly inadequate doses which are rejected by the patient with disengagement from services, and evidence for high dosing to be safe if tolerance testing is systematic (1). The impression of our clinicians is that the higher methadone doses are given to individuals who have only been out of treatment a very short time, and even though the study method was not able to always recognize such gaps, we feel certain that such an influence on high or low initiation is relevant in our current practice.

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