5.9 Under-dosing and poor initial assessment undermine success of English methadone services

Findings Two reports from England's National Treatment Outcome Research Study (NTORS) have confirmed that the benefits of outpatient methadone prescribing persist for at least two years. They also found that a fifth of opiate addicted patients do not respond well to what is often an ill-defined programme not delivered as intended.

Findings at one year were based on interviews with about 70% of the 667 patients who in 1995 had entered 31 methadone programmes report ❶. Two-year findings were based on nearly 90% of a random sample of the intake report ❷. Programmes were categorised as maintenance (stable non-reducing doses) or reduction (maintenance to abstinence over a variable period). Patients in both had similar drug-related problems, though in reduction programmes they were younger, had used heroin for a slightly shorter time, and fewer were polydrug users. At both follow-up points improvements at six months had persisted, including (compared to intake levels) a halving in the number of days on which heroin had been used in the past three months and cuts in use of other drugs. Alcohol use had changed little and at two years is known to have remained excessive in over a fifth of the patients. There were large reductions in acquisitive and drug selling crimes and physical and psychological health had improved. Once variables such as problem severity had been taken into account, there were no statistically significant differences in the degree of improvement in the two types of programme.

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Report ❶ found that improvements were concentrated in the 59% of patients who at intake were the most frequent heroin users, particularly the quarter also frequently using benzodiazepines. Even these 'good responders' were still using heroin on average once or twice a week. In contrast, in 18% of patients neither drug use nor sharing of injecting equipment had been reduced, and benzodiazepine use had significantly increased; only drug selling (but not acquisitive) crime had significantly improved. Another fifth of patients showed only modest improvements, probably because they had already minimised drug use and related problems during previous methadone treatments. This pattern of outcomes is likely to have persisted to two years.

Report ❷ reveals that for 240 patients the initial treatment plan was maintenance and for 111 reduction over a generally unspecified period. Over the first year, 70% of patients intended for maintenance received it, but only 36% intended for reducing doses actually received them. For most of the remainder doses were stable enough to count as maintenance. From six months on, retention was higher among patients planned to receive maintenance. Among these patients each mg more methadone per day was associated with a 2% reduction in the risk of regular heroin use; compared to leavers, those retained were half as likely to be regularly using heroin. Patients more severely dependent at intake gained most, and not just because they received more methadone. Patients intended for methadone reduction did slightly less well the more times doses were cut in the first year. Across both groups, reductions in heroin use were associated with improvements on a composite measure of health, other drug use, and crime. On the same measure, the more severely dependent a patient was at intake the less well they tended to do if methadone reduction was the planned treatment.

In context The fact that reduction programmes had shorter retention times than maintenance yet achieved equality of outcomes was not because they resolved patients' drug problems; at one year 70% were still in some form of treatment. Internationally, retention and heroin use are worse in slow reduction than in maintenance programmes, mainly because they tend to prescribe lower doses of methadone during the stabilisation phase and because outcomes deteriorate during the reduction phase.

Low doses in British clinics are a concern because higher doses of methadone generally result in better retention and better outcomes. However, the absolute number of mg per day is less important than adjusting this individually in response to illegal opiate use or patient distress. Where a clinic's adherence to maintenance and harm reduction objectives permits flexible adjustment of doses to high levels, patients who would have been seen as treatment failures elsewhere have achieved excellent outcomes. Because each patient is receiving the dose they need, in such clinics the absolute dose level is no longer related to outcomes. Low average doses, few increases, and the tendency to aim first for reduction, seem symptomatic of a reluctance to fully embrace maintenance and harm reduction. Outcomes suffer in clinics where such attitudes are prevalent.

Practice implications Greater severity of opiate dependence is a strong indication for offering maintenance as opposed to reduction. As currently practised, methadone treatment in Britain achieves substantial benefits, but there is considerable room for improvement. Even in patients responding relatively well to treatment, dose levels are below those needed to adequately control heroin use. A fifth or more of patients appear to be in the wrong treatment or to need greater doses or greater support in order to improve. Intended methadone reduction often ends up as low dose maintenance with poorer retention than explicit maintenance, falling between two stools and meeting the objectives of neither. Assessment and treatment planning should be geared to meeting individual need rather than clinic policy on reduction/maintenance. Clarity over what treatment the patient is now receiving should help to establish objectives (harm reduction or abstinence) and ensure that the treatment plan corresponds to those objectives, without losing the current flexibility to change that plan in response to re-assessments. Explicit agreement on maintenance removes the pressure on patients to accept low and reducing doses which dominates many clinical sessions. A maintenance and harm reduction orientation would mean that continued heroin use is seen as an indication for a dose increase. Where instead a disciplinary reaction with possible dose reduction is the usual response, staff-client relationships suffers and treatment effectiveness is put at risk.

Featured reports ❶ Gossop M., *et al*. "Patterns of improvement after methadone treatment: 1 year follow-up results from the National Treatment Outcome Research Study (NTORS)." *Drug and Alcohol Dependence*: 2000, 60, p. 275–286 ❷ Gossop M., *et al*. "Outcomes after methadone maintenance and methadone reduction treatments: two-year follow-up results from the National Treatment Outcome Research Study." *Drug and Alcohol Dependence*: 2001, 62, p. 255–264. Copies: for both apply DrugScope.

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