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▶ Methadone prescribing under supervised consumption on premises: a Scottish clinician's perspective on prescribing practice.

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Survey responses from clinicians prescribing methadone at Scottish addiction treatment clinics show how the requirement that patients be observed taking the medication involves striking a balance between safety, individualising treatment, and attracting and retaining patients.

Summary Requiring opiate dependent patients to take substitute medication under observation at the pharmacy or clinic is a common way of improving initial safety and compliance with the treatment, and preventing medication being taken by other people or diverted on to the illicit market. Depending on the individual patient and on their compliance with treatment, UK guidance recommends consumption be supervised for at least the first three months of treatment. The featured study aimed to establish the extent and nature of supervised consumption at specialist drug dependence treatment centres (ie, not at GPs' surgeries) in Scotland by means of a postal survey in February 2009 of all 42 clinical leads in substance misuse in Scotland, of whom 32 completed and returned the forms.

Main findings

Of the 32 respondents, 20 said they required supervised consumption of new patients for at least three months and 15 said the same of returning patients. For new patients, all but five required supervision six days a week. About half the clinicians said they relaxed these requirements gradually, though it was not unusual for clinicians to support long-term or indefinite supervision. Safety was highlighted as the key reason for supervising consumption, particularly preventing methadone being taken unsafely by people other than the patient. The decision to relax this requirement was made partly on grounds of safety (including that of children in the home who might inadvertently consume take-

home medication) and partly on the basis of indicators that the patient was socially and psychologically stable, complying with treatment and no longer using illicit drugs.

Twenty of the respondents indicated that they used the relaxation or imposition of supervision as a way of shaping the behaviour of the patient, most commonly to encourage the cessation of illicit drug use as confirmed by urine tests.

Eight of the 32 clinicians believed that supervised consumption deterred some people from starting treatment and 13 that it led some to drop out prematurely due (among other reasons) to inconvenience or conflicts with work, education or family obligations.

The authors' conclusions

Clinicians who responded to this survey usually required supervised consumption for at least three months and took the individual patient's needs and situation in to account when deciding to relax this requirement, balanced against a keen awareness of the danger posed to other people by 'leaked' methadone. What might be seen as the 'vagueness' of national guidelines created the space for the patient-centred approach important to many clinicians.

The Scottish drugs strategy's focus on recovery, entailing moving on in treatment and seeking employment, may require some relaxation of the requirement for supervised consumption. The ambition to increase the numbers in treatment may also require the rethinking of a requirement which imposes considerable cost and absorbs considerable staff time. These decisions would benefit from an assessment of evidence on the effectiveness and cost-effectiveness of different models of supervision, for example, no supervision versus daily or twice-weekly supervision. Such an assessment would also have to consider the wider societal implications of reverting to less restrictive approaches.

FINDINGS Findings analyses related to supervised consumption can be found by running this search. Among the retrieved studies is one of methadone overdoses in Scotland and England, which supports clinicians' safety concerns and beliefs that supervised consumption is an important aid to improving safety. It concluded that the recent decline in the per-dose rate of deaths due to methadone overdose was due to the spread of supervised consumption, and that this was 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. To the degree that (as some clinicians in the featured study believed) it causes dependent opiate users to avoid or drop out of treatment, it could impede substitute prescribing realising its lifesaving potential. Beyond methadone patients and potential patients are the other adults and children who might risk their lives by consuming methadone stored in the home or passed on by patients. These deaths too can be expected to be curtailed by supervised consumption, but the impact on overdose on opiate-type drugs as a whole is less easy to predict. Below a summary of research on these and related issues based on a Findings review.

Research confirms that anti-diversion regimens which include supervised consumption are associated with reduced diversion and that the risk of diversion is greatest among patients yet to achieve stability, marked for

example by appropriate housing, employment, and reduced illegal drug use. Research is contradictory with regard to the impact on outcomes and retention. This may be because two opposing influences are at play. Especially when it can be made convenient for the patient, supervised consumption can enhance retention by giving structure to lives newly devoid of the structure imposed by acquiring and using illegal drugs, by ensuring regular clinical contact, and by preventing patients straying back to illegal drug use. Sometimes patients are aware of these dangers and resist increased take-away dispensing. Others relapse when take-aways are extended across the board rather than restricted to stabilised patients.

On the other hand, patients find it difficult to comply with long-term attendance or supervision requirements, leading to reduced compliance and premature drop-out or discharge. Patients may understand the need for supervised consumption in the initial stages and for 'chaotic' patients, but object to its continuation when individuals have 'proved' themselves. Extended supervision is generally unpopular with patients. In some countries where consumption is at the prescribing clinic, it contributes to long queues and congestion which foster disputes, facilitate drug-based social networks, and create a counter-therapeutic environment. It also risks restricting the development of the patient's responsibility for their lives, and displacing therapeutic activities and relationships by policing and control. Patient autonomy is undermined because they are unable to control the timing and staging of their medication consumption. This freedom might be exercised to facilitate illegal drug use, but may also be used it to reduce it. Frequent clinic or pharmacy visits obstruct reintegration in to employment and family responsibilities and make it difficult for patients to keep their condition secret.

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