DRUG & ALCOHOL FINDINGS Hot topic

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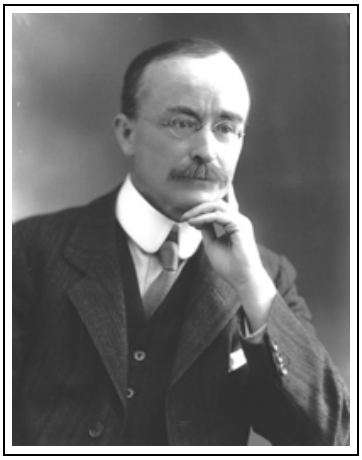
GO Prescribing opiate-type drugs to opiate addicts: good sense or nonsense?

Like its opposite treatment pole residential rehabilitation, prescribing opiate-type medications to opiate addicts on a long-term 'maintenance' basis acts as a focus for political and professional controversy, poles to which opposing treatment philosophies pin their colours. No other treatment for opiate addiction has a longer and deeper history of controversy, none such proven potential to save lives, and no other so divisively galvanises current politics.

From at least the 1920s, maintenance prescribing, including of injectable heroin, was the defining feature of what overseas observers envied as the humane British way of treating addiction – the so-called 'British system'. It never really was a 'system', because its essence was to give doctors and patients wide latitude to exercise discretion over what was best for the patient, a contrast to the tightly regulated US example. As it has been several times in the past, today that latitude is being challenged, this time in the name of 'recovery'. Take a seat and listen to the arguments – and see what you think.



Sir Malcolm Delevingne: Home Office drug policy official 1913 to 1932; wanted what we now know as maintenance prescribing declared "not legitimate" practice ▶ below

Uniquely successful, uniquely controversial

Of the available opiate-type medications, buprenorphine is the mainstay in France, and morphine, heroin itself, dihydrocodeine and other opioids have been used, but worldwide and in the UK, methadone is the dominant choice. A long-acting drug taken orally just once a day, and in this form lacking the euphoric impact of heroin injection, ideally methadone divorces addicts from the dangerous roller-coaster of injecting several times a day, and from the need to devote their lives to financing and using drugs purchased at inflated prices on the illegal market. Underlying both its success and the condemnation is that prescribing opiate-type medications to opiate addicts goes with the grain of their addiction and seeks to smooth out the harm and if possible nudge towards a drug-free life, rather than trying rapidly and forcefully to rub the opposite way towards abstinence.

Among overwhelmingly poor and unemployed treatment caseloads, rapid reduction in illegal opiate use and consequently in health risks and revenue-raising crime is the typical result. Lives are stabilised and turned around in quantities unavailable from any other treatment modality, partly because other treatments offer less or demand more up-front commitment to an opiate-free life. Such is their public health importance that the World Health Organization has recognised methadone and buprenorphine as 'essential medicines'. Downsides include remaining reliant on high doses of opioid drugs, tying patients to a regimen hard to leave due to dependence and to withdrawal symptoms. Though benign compared to illegal heroin injecting, still there are social (stigma perhaps the prime one) and health impacts, including elevated risks of overdose death during induction and if patients take other drugs. Few people like to have to regularly take any medication, but these patients' lives are often severely restricted by the demands of the treatment and associated regulations and practices, like having to attend clinics or pharmacies every day to take medication in front of staff.

Commentators unlikely to see eye to eye on other issues have condemned maintenance prescribing in terms rarely if ever applied to any other addiction treatment, while researchers and international authorities have promoted it as the most successful approach to dependence on heroin and other opioid drugs, one which probably has saved more lives than any other. In 2011 opposition to opioid maintenance was described as "intense, universal and timeless". With over 40 years' experience in the field, the writer had seen visceral opposition sustained even where programmes had become widespread. Though they may be the dominant treatment response to opioid addiction, such programmes rarely enjoy comfortable acceptance as legitimate medical practice in national policy and in political and public understandings. In the next two sections, we sample some of the more extreme positions, before looking at how the arguments have played out in Britain.

"A hidden way to surrender"

Surveying the spectrum of drug-based treatments for substance use problems, only in respect of "longer-term methadone maintenance" was a review for the British Association for Psychopharmacology moved to comment, "Opinions and practice are strongly influenced by political/social context." Exemplifying how tangled this medical treatment has become with morals, in 2014 Pope Francis saw it as compromising with the "evil" of drugs: "Substitute drugs, moreover, aren't a sufficient therapy, but rather a hidden way to surrender ... No to every type of drug. Simply no to every type of drug."

Substitute 'poison' for 'evil', and you are close to what has been portrayed as the dominant thinking in nineteenth century Britain on the 'chronic poisoning' caused by long-term regular consumption of opium or morphine. Rather than continuing this, experts argued that if the "patient is being poisoned ...the poisoning must be stopped ... were it arsenic instead ... no one would dispute this." Later in the century the evident distress of the patients and their unwillingness to cooperate, the consequent requirement for unpalatable restrictions on their liberty, and a zeitgeist lauding regularity in all things, including medicines, led to what we now know as substitute prescribing, whose essence was the expert control of regular doses to maintain stability.

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These viewpoints remain unreconciled in today's debates, recognisable in the barrement of commentators who see substituting one opiate-type drug for another as merely swapping poisons, and in the disciplined regularity of substitute prescribing programmes.

"State's attempt to inculcate moral discipline into ... deviants"

Despite being posed as competing medical approaches, medically supervised withdrawal of the 'poison' and its continued administration shared an important feature – that control was taken out of the hands of the 'ignorant' patient and placed in the hands of experts. What they see as dehumanising 'control' also lies at the heart of leftist critiques of methadone programmes from commentators very far from damning all drugs as evil or poisons.

Neo-Marxist anthropologist Philippe Bourgois saw US methadone clinics as more firmly and damagingly addicting street heroin addicts than heroin itself – "the state's attempt to inculcate moral discipline into the hearts, minds, and bodies of deviants who reject sobriety and economic productivity ... a Calvinist-Puritanical project of managing immoral pursuits of pleasure and of promoting personal self-control in a manner that is consonant with economic productivity and social conformity." Here the images are of the hobbling of anti-establishment outsiders and rebels by the chains of a dependence harder to break than heroin, which forces them to cede control over their lives to the authorities they previously challenged, evaded or rejected. Ironically, in the UK today getting patients off methadone is seen as route to "economic productivity and social conformity".

In more intemperate terms, Thomas Szasz, a radical American professor of psychiatry, characterised maintenance as the problem, not the solution: "To my mind, however, maintenance is the disease ... the gas chamber to which the Blacks go as willingly as the Jews went in Germany." Unrepentant when challenged, his line was that opiate habitués are forced to become 'patients' of methadone clinics because their preferred drug (heroin) is proscribed for no better reason than that it is out of favour with authorities in a position to enforce their view of what counts as a 'good' legal drug, and what as a 'bad' illegal one.

Blair's boom era

In the UK recent arguments over maintenance prescribing took different forms in the different nations. This account focuses largely on the UK government's stance, which most directly affected England.

For former 'New' Labour leader Tony Blair, getting more heroin addicts into treatment was a key tactic in his strategy developed while in opposition to be "tough on the causes of crime" as well as tough on crime itself. During his decade as prime minister from 1997 to 2007, the amount of methadone prescribed in England and Scotland increased from 588 kg to 2051 kg. Holding back impacts both on crime and on health were the fact that only a minority of addicts were in treatment, a gap which in 2001 the National Treatment Agency was established to help close by doubling the treatment caseload. In this they succeeded: by 2007/8 the caseload exceeded 200,000 in England alone. It was a boom time for addiction treatment with methadone in the vanguard, but elsewhere a very different rhetoric was gaining ground.

Then in opposition, in July 2007 David Cameron's 'New' Conservatives released the fruits of their addictions policy think tank. No barb was sharper than the claim that "maintenance methadone prescribing which perpetuates addiction and dependency has been promoted under current policy while rehabilitation treatment has been marginalised" – a sentiment which translated into addictions treatment policy the Conservatives' determination to reduce dependence on the state in the form of welfare benefits.

The report came from the Social Justice Policy Group chaired by Iain Duncan Smith, whose trenchant views figure prominently in today's debates. Three months later the National Treatment Agency's crime-reduction justification for investing in treatment was challenged by the BBC's straightforward assumption that treating addiction ought to be about getting people off drugs. Even after correcting the BBC's mistakes, the agency's own figures showed that in England at the end of 2006/7, just 3% of people in treatment for drug problems that year had completed it and left drug-free, confirming the substance of the attack.

The addiction policy tide was turning towards what became known as 'recovery', and the main rhetorical casualty was methadone maintenance. By 2010 the political tide too had turned, and maintenance prescribing's critics had a chance to put their views into practice.

Iain Duncan Smith: Leading Conservative critic of substitute prescribing – "perpetuating drug addiction"

UK government opposes maintenance to 'full' recovery

Divisions over opiate substitute prescribing were reflected in the policies of parties contesting May 2010's election, from the Greens who wanted more heroin prescribing, to the Conservatives, whose accusation that methadone maintenance was "drug dependency courtesy of the state" could have seen them sharing a platform with radical neo-Marxist Philippe Bourgois ▸ above. Labour's plans responded to this criticism, but without abandoning the mass methadone programme which they believed had cut crime and curbed infectious disease.

Dismayed by attacks on methadone, in April 2010, 41 British and international experts came together to defend "this life-saving treatment", an unprecedented alliance which shows how seriously they took moves to curtail it. Time limits were on methadone critics' agendas, and were to repeatedly return. Then as later, the experts rejected them: "If policymakers were to heed the critics' advice to close down methadone treatment, or impose an arbitrary time limit on its administration, the community can anticipate more overdose deaths, more HIV and more crime."

In the event, the national drug strategy of the Conservative/Liberal Democrat coalition which took power rowed back from the pre-election rhetoric, offering sometimes contradictory sentiments from which both poles of the debate could take comfort. One short, key sentence ("Medically-assisted recovery can, and does, happen.") brought substitute prescribing in from the cold and under the umbrella of 'recovery', a safer political haven. But at the same time the strategy heralded a determined attempt (for most, but not all patients) to eliminate the distinguishing feature of 'maintenance' prescribing – its indefinite and often long-term nature – downgrading its role to a *preparation* for "full" recovery rather than a continuing platform for sustaining recovery.

Picking up the baton, the 2010-11 annual plan from England's National Treatment Agency for Substance Misuse

Picking up the baton, the 2010–11 annual plan from England's National Treatment Agency for Substance Misuse heralded the end of maintenance prescribing for all but a minority of patients. The bulk would be offered "a time-limited intervention that stabilises them as part of a process of recovery, not as an end in itself". The agency recognised this would be a "radical reform" with risks evident in several studies. Most notable was a rare randomised trial which had allocated US patients either to minimal-support methadone maintenance or enriched-support but more time-limited stabilisation followed by detoxification. Despite extra support, detoxification patients used more illegal heroin and were predicted to on average die sooner, making maintenance a cost-effective life-extender. The study remains the most stringent test of maintenance versus something more like what the critics were looking for – a short-term role with intensified support leading to drug-free recovery.

With methadone maintenance officially accepted as not inherently incompatible with recovery, critics found another way to signal what they saw as its relatively low recovery credentials. The term 'full recovery' gained currency to variously mean lifestyle change beyond remission of dependence and/or becoming drug-free, including free of maintenance prescribing. Its implication was to deprive maintained patients of 'fully' sharing in the favoured status of being 'in recovery', while not flatly contradicting the official line.

Most prominently, in 2012 the term featured in the title (*Putting Full Recovery First*) of "the Government's roadmap for building a new treatment system based on recovery, guided by three overarching principles – wellbeing, citizenship, and freedom from dependence". That last phrase was a reminder of struggles in developing the 2010 national strategy over whether dependence, or drug use itself, was the disorder to be treated, a struggle won by the dependence lobby. But as in the strategy, the abstinence objective was not totally abandoned, leaving mixed messages with implications for the centrality and longevity of maintenance prescribing.

Putting Full Recovery First's promise was to bring "an urgent end to the current drift of far too many people into indefinite maintenance, which is a replacement of one dependency with another ... Where substitute prescribing is used, it will be accompanied by recovery-focused support to maximise a person's chance of freedom from any chemical dependency. People in treatment will be expected to be increasingly engaged in planning for their treatment, with for example individuals plotting a list of objectives and regular actions to take them on their recovery journey." The sentiments were a precursor to the challenge (next section) made to an expert group whose report was supportive of maintenance to stipulate that the treatment must be regularly re-assessed with a view to patients moving on.

Addiction treatment sector fights back

Debate came to a head when in 2012 an expert group convened for the UK Department of Health by the National Treatment Agency for Substance Misuse delivered its guidance on how methadone and other medications can more fully aid recovery.

Led by addiction psychiatrist Professor John Strang of the National Addiction Centre, the committee sought to reconcile competing perspectives. Facing forward, they tried to show that these treatments can be part of the new recovery agenda, despite that agenda's associations in some quarters with abstinence from all drugs including legal substitutes (no methadone) and with leaving treatment (no or curtailed maintenance). At the same time, their report faced backward to protect previously accepted views critiqued and threatened by this agenda: the need for long-term indefinite prescribing in the face of the tenacity of heroin addiction and the vulnerabilities of its sufferers; the legitimacy in recovery terms of staying in as well as leaving treatment; and the value of harm reduction objectives and achievements short of what it accepted was the abstinence ideal.

After the report's publication the Chief Medical Officer sought further guidance, including how often patients should be reviewed to determine "whether alternative treatments should be tried" – a sign that government concern over patients 'getting stuck' in maintenance programmes had not been assuaged by the initial report. The group's response published in 2013 moved some way to meet the agenda presumed to lie behind the questions, advising that six-monthly reviews should "revisit recovery goals and pathways" with a view to supporting clients "to move towards a drug-free lifestyle". Nevertheless, the reply may have left the instigators of the question dissatisfied, maintaining the initial report's opposition to "arbitrarily or prematurely curtailing opioid substitution treatment", its insistence that such decisions are for the individual patient and their clinicians, and that both will need to balance risk and maintenance of gains with the ambition to move on.

If at first you don't succeed ...

Seemingly having not prompted the answers they wanted, in 2014 the Government turned to its official advisers on drug policy on the Advisory Council on the Misuse of Drugs. To them the question was "whether the evidence supports the case for time-limiting opioid substitution therapy". It would have added to the four similar requests recalled by Paul Hayes, former head of England's National Treatment Agency for Substance Misuse. In 2013 he commented, "There's still an appetite in bits of government to re-ask the question about time-limited methadone ... which in my time they asked four times and always got the same answer. They keep hoping they'll finally find someone to tell them what they want to hear, but the evidence remains the evidence."

This latest government attempt to "find someone to tell them what they want to hear" was the one which in public most explicitly sought grounds for setting time limits to opioid substitute prescribing. The resulting rejection was also the most explicit to surface from an official body. Not only did the report foresee negative health and crime consequences from time limits or otherwise curtailing prescribing, but it turned the tables by arguing that far from being in treatment too long, generally patients in England were there too short a time, and that rather than restricting access to maintenance, access should be widened. In this they echoed the comments of US recovery 'guru' William White for a Scottish report (▸ below) which, as in the UK as a whole, had responded to government concerns over the role of methadone in recovery. The Advisory Council extended the argument from research evidence to medical ethics and practical feasibility, resulting in a report which can be seen as comprehensively repelling the anti-maintenance lobby within government discerned by Paul Hayes.

But in the person of Iain Duncan Smith, leader of the Department for Work and Pensions, that lobby remained unconvinced. A few days after the report's release, his response in the *Sunday Telegraph* made some extraordinary accusations. As the newspaper put it, he urged his colleagues to "fight 'vested interests' in pharmaceutical companies and treatment centres who profit from 'merely replacing one addiction with another' by keeping addicts hooked on legal heroin replacements." Despite the evidence to the contrary gathered for the Advisory Council's report, he stuck by his "parked on methadone" analogy, and accused advisers appointed by his own government of "providing cover for perpetuating drug addiction in the UK" – a slur the gravity of which can hardly be exaggerated.

Mr Duncan Smith's stance was strikingly reminiscent of that taken two decades earlier by another Conservative minister, Dr Brian Mawhinney. From his influential position as Minister of State for Health, he had condemned the " 'drug industry' who resist any threat to their present autonomy" ... and by 'drug

industry' who resist any threat to their present autonomy" – and by 'drug industry', he meant the addiction treatment sector. With what could have make-or-break consequences for that sector, he set up a review which its chair said was partly driven by concern that "treatment might often be insufficiently oriented towards the attainment of abstinence. More specifically ... there were those who questioned the acceptability and legitimacy of methadone maintenance programmes, which seemed to some simply to replace an illegal drug with a similar drug legally prescribed". Ironically, Dr Mawhinney's review commissioned its key research project from the heart of the industry he saw as resisting interference, the National Addiction Centre – the same body whose leader chaired the group which in 2012 and 2013 was to field another Conservative-led government's concerns about maintenance prescribing ▸ above.

Dr Brian Mawhinney: Conservative health minister in the early 1990s who set up an inquiry into the legitimacy of methadone maintenance programmes

Like Dr Mawhinney, Mr Duncan Smith also established a review. As in the 1990s, it ended up by backing almost a reverse position to his own. This time the review was conducted by his own Department for Work and Pensions to determine whether the public purse would gain by sending more opiate-dependent clients to residential rehabilitation – the modality favoured not just by Mr Duncan Smith, but also by the prime minister. Instead the resultant report suggested that including the costs of treatment itself, non-residential options dominated by substitute prescribing programmes were a better deal for society if the aim was to contain public sector costs. Treatment pathways featuring residential care seemed if anything only a long-term winner which *might* prove more cost-beneficial 12 or 13 years down the line – a prospect so beset with uncertainties and unrealistic assumptions that it was effectively dismissed. On balance the report judged it "highly unlikely" that the higher cost of residential pathways would be offset by greater public sector savings compared to non-residential pathways.

How can we make it better?

One feature of Iain Duncan Smith's critique has been replicated in other similar complaints – that methadone programmes lack the psychosocial and rehabilitative support needed to accelerate patients out of treatment and into recovery. Instead of attributing this to overstretched resources – and promising further funding – he condemned the programmes as inherently non-progressive. But if methadone's recovery credentials lacked shine, it may have been because per treatment episode far less was invested than in the Conservative leadership's favoured residential rehabilitation option.

How maintenance programmes might be made more progressive was the subject of a further Advisory Council report, produced in response to another question in the same government request (▸ above) which prompted the council's report on time limits. If time limits were not on, "how can continuing opioid substitution therapy be optimised in order to maximise outcomes for service users?" was the question. A further question asked about reviewing treatment if the therapy was "not working" – the same issue put to the expert group chaired by Professor Strang, but this time escalated to a question about whether in these circumstances review should be "mandatory". It represented an extraordinary sally into government potentially determining the details of how patients should be treated, presumably entailing their pinning down what 'not working' consists of, at odds with the customary insistence that recovery is an individualised journey.

The Advisory Council's reply cycled back to the reports (▸ above) from the expert group chaired by Professor Strang, which it found "excellent and of high quality, and evidence-based". To ears tuned like those of Iain Duncan Smith, it might have been the sound of the 'vested interests' in addiction joining ranks to repel unwanted political boarders.

This latest expert response to official misgivings placed itself on the government's side in wishing to promote 'recovery' and in its concerns over treatment quality – but rather than reigning in substitute prescribing, implementing its recommendations implied maintaining current caseloads while putting more resources in to fuel a "national quality improvement programme for recovery-orientated [opioid substitution therapy] and ensure implementation of evidence-based practice". Even then, the council warned that for many heroin addicts, transition in the short-term to drug-free, 'model citizen' status was unrealistic; attempting abstinence was risky and "often results in lapse or relapse".

The Advisory Council's recipe for enabling more patients to make more progress included investing in higher doses, extending provision of more expensive medications, greater access to psychosocial interventions delivered by qualified practitioners including family and couples therapies, more mental health and medical care, vocational and housing support, more testing for drugs and supervised consumption of medications, greater access to options including inpatient detoxification and residential rehabilitation, and a move away from frequent re-commissioning rounds ending in cheaper treatment systems with less qualified and less expensive staff. The keys to recovery lay not just in treatment, but in the social, welfare and medical services being cut back under the goverment's austerity agenda. If the government wanted more recovery, it would have to pay for it in enriched treatment and in more recovery-friendly public services.

Maintenance is not the problem, says Scottish expert committee

In Scotland too, getting more recovery out of maintenance prescribing was on the government's mind when the Scottish Drugs Strategy Delivery Commission was asked by the Chief Medical Officer to recommend ways to maximise the effectiveness of methadone and allied treatments. The CMO's foreword to the resulting report hinted at the concerns leading to his request – that methadone treatment "often simply switches one pattern of drug use for another" and "is far from risk free" – an allusion to the concern in Scotland about overdose deaths linked to the drug. It also reflected a core concern in Scotland and in England too – that commissioners have allowed methadone to dominate treatment provision to the point where other options are in practice excluded.

Despite substitute prescribing's demonstrated strengths, the report found "The evidence-base for effectiveness in achieving abstinence or promoting long term recovery – as opposed to reducing harm – remains much less compelling," possibly due to inadequate research. Nevertheless, for the committee there was more than enough evidence that methadone maintenance is an "essential" component of treatment services whose costs are justified by its "extensive impact ... on health, criminal justice, social care, costs to the economy and wider costs to society".

For these experts, long-term indefinite treatment was not a problem: "for maximum long term benefit some may require to receive [opioid replacement therapy] indefinitely ... this outcome ... should not be considered a failure". Instead they saw the main problem not as maintenance prescribing itself, but the lack of alternative and ancillary services which can support further progress towards recovery. This call to improve quality and to set up a system to monitor

improvement was in November 2013 answered by the Scottish government, whose response included requiring each

improvement was in November 2015 answered by the Scottish government, whose response included requiring each local substance use strategy partnership to develop a plan for responding to the recommendations.

Echoing the Advisory Council on the Misuse of Drugs (▸ above), the Scottish report featured comments from US recovery 'guru' William White which turned the tables on concerns that patients spend too long in maintenance programmes: "In the US, there are periodic moral panics about the idea of patients being on methadone for prolonged periods – an image that obscures the real problem which is that most patients are not on methadone long enough, eg, high rates of early drop-out, administrative discharge and rapid resumption of opioid addiction." His comments will be difficult to dismiss as the self-serving intervention of someone with a vested interest in perpetuating addiction and impeding recovery; no-one worldwide has greater credibility and respect as a recovery advocate.

Pre-recovery roots

English and Scottish expert reports both posed a seemingly insoluble conundrum: part of the impetus for challenging long-term prescribing has been to contain costs, yet supporting people to the point where they can safely leave, making sure they remain safe, and offering greater access to alternatives like residential rehabilitation, is likely to cost even more.

At least in England, the roots of this issue date back to concerns of pre-2010 Labour governments to contain costs, free up treatment slots, reduce dependence on the state, and get patients back to work. Well before the discovery of recovery as an overarching rationale, the emphasis had already shifted to getting patients out of treatment, partially reversing the previous emphasis on keeping them in. Since long-term retention in continuous treatment is characteristic of opioid substitute programmes, the sometimes unspoken challenge was to the dominance of this approach in the treatment of heroin addiction. As early as 2005 an "effectiveness" strategy developed by the National Treatment Agency for Substance Misuse was partly a response to concerns about the "lack of emphasis on progression through the treatment system" leading to "insufficient attention ... to planning for exit". Foreseeing a time when funding would be less available, the agency's board was told that "Moving people through and out of treatment" will create the space for new entrants "without having continually to expand capacity".

Britain had arrived at this point after decades when it alone permitted heroin for the treatment of heroin addiction, resting on freedoms confirmed for doctors and patients by the 1926 Rolleston report. The 2012 expert group's insistence (▸ above) that the nature and duration of treatment are essentially matters for clinician and patient, not to be dictated by commissioners or national policy, maintained the position established by Rolleston's report. Home Office official Malcolm Delevingne had sought a declaration that "regular prescription of the drugs on the ground that without them the patient will suffer or even collapse ... is not legitimate and cannot be recognised as medical practice", one aspect of his attempt to subjugate medical practice to an essentially penal drug policy. Instead the resulting medical committee chaired by Sir Humphry Rolleston (▸ illustration above) safeguarded the privileged doctor-patient relationship, endorsing the legitimacy of long-term regular doses for patients who could lead a "fairly normal and useful life" with narcotic drugs, but not without them.

But in Rolleston's time too, there was disquiet about long-term maintenance prescribing, some witnesses to the inquiry denying the need, others admitting to it "with reluctance". In a striking echo of today's contentions, the report repeatedly referred to the lack of suitable institutions in which to effect a residential cure – the equivalent of today's 'full' recovery. Had these institutions been widely available at a price most people could afford, and with powers to detain patients, then, the committee mused, perhaps everyone could be treated and maintenance would be unnecessary – and probably improper. Even more so now, and even were it desirable, the prospect of a network of therapeutic detention centres capable of housing and promoting the recovery of many tens of thousands of patients seems remote.

Still with the grain, but more abrasive

Since Rolleston's time the UK has moved away from maintenance regimens which most closely followed the grain of the original addiction by prescribing the same drug to be taken in the same manner and, if patients wanted, in their own homes. In the 1950s and '60s, respectable middle and upper class opiate-dependent patients were displaced by non-rule following drop-outs and working class addicts with hedonistic drugtaking rather than relief of distress on their minds. Even with a regular supply of drugs, it would have been difficult for the establishment of the time to see them living a "fairly normal and useful life". Moving away from individualised care, it was the cue for the latitude gained by Rolleston to constrict in the interests of controlling what was seen as a drugtaking "epidemic". In 1968 heroin prescribing for addiction became almost exclusively restricted to a few hundred specialists working from hospital clinics, easier to control than independent GPs and private practitioners. Having enticed the addicts in to these more controlled settings, in the 1970s the UK moved decisively to switch them to the more 'normalising' oral methadone option pioneered in the USA.

From the mid-1990s, mainland European countries trialled and then adopted the heroin prescribing option Britain had largely abandoned, adding the requirement that the heroin be injected under medical supervision at the clinic. This continental approach cycled back to Britain via the RIOTT trial, which found that for patients who had previously not done well on methadone, heroin prescribing featuring supervised consumption suppressed illegal heroin use much more effectively than oral methadone. If we accept (▸ above) the 'state control' formulation of radical critiques of substitute prescribing, the shackles had been tightened even further on these formerly non-compliant patients, requiring twice-daily clinic visits and the relegation of a renegade act of hedonism to the supervised taking of a medication in hygienic and highly controlled circumstances. Perhaps this was why patients were hard to find for the trial, but for some who did join, it was a turning point in their lives, and perhaps saved them. If substitute prescribing is a double-edged sword, here it was at its sharpest.

If we needed it, RIOTT provided an indication that important keys to transforming maintenance outcomes into more like the government's recovery ambitions lie outside the addiction treatment clinic. Despite its greater success in curbing illegal heroin use, at least in the short term heroin prescribing did not do more to improve wider drug use, crime, social reintegration, and physical and mental health. Whether prescribed oral methadone or injectable heroin, patients still faced the same housing, education, employment, financial, mental health and stigma barriers to a more fulfilling life.

Evidence informs but does not decide

Arousing visceral opposition and passionate defence, prescribing opiate-type drugs to opiate addicts for as long as needed and on the discretion of the doctor treating the patient, has for decades been the mainstay of heroin addiction treatment in Britain. Because opposing camps value different things, evidence alone will not decide whether it stays that way, but research does reveal what we and the patients stand to lose or gain from a change in policy. To help you narrow in on your main interests, we offer three custom-made searches:

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Thanks for their comments on this entry to: Annette Dale-Perera, co-chair of the Recovery Committee of the Advisory Council on the Misuse of Drugs; Paul Hayes, head of the National Treatment Agency for Substance Misuse until its absorption in Public Health England; and to Ian Walmsley of the University of the West of England, author of the 'poisoning' analysis referred to above. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Mike Ashton, the author of this hot topic for the Effectiveness Bank, is a member of the committee of the Advisory Council on the Misuse of Drugs responsible for some of the reports referred to, though not a member of the Council itself and not involved in drafting the reports.

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