Many people in treatment for heroin addiction are prescribed methadone. A single dose of the long-lasting synthetic opiate helps people through the day without cravings or withdrawal symptoms and makes it possible for them to rebuild a life that doesn’t feature crime and the risk of hepatitis and HIV from shared needles.

When treatment starts, people take their daily dose as a pharmacist or addictions professional watches. Supervision continues until people are stable on methadone treatment and proven to be off heroin completely.

When methadone maintenance treatment first became commonplace in England in the late 1980s and through the 1990s, however, this was not case. As a result, the death toll from overdoses of the prescribed substitute was almost equal to the number of deaths due to heroin overdose.

‘Methadone is a product that is therapeutically valuable, a product that can turn people’s lives around, but the way we were delivering the treatment was doing harm, and there was great concern about the large number of deaths,’ says Professor John Strang.

In 1995, Professor Strang and colleagues at the National Addiction Centre (NAC) carried out a survey of high street pharmacists in England and Wales. They found that people on methadone treatment were not being given any sort of supervision, and were left to their own devices after prescriptions were filled.

This meant methadone was being sent home with the risk of overdose, double dosing with heroin, storing the drug insecurely and potentially putting children at risk, or selling it on the black market. ‘Many of the deaths from overdose were deaths of people who had not been prescribed methadone,’ says Professor Strang.

The research influenced the recommendations of a Department of Health task force report, published in 1996, suggesting supervised dosing of the recommended daily dispensing of methadone.

Three years later, the Department of Health and corresponding departments in Wales, Scotland and Northern Ireland published their ‘orange guidelines’ which recommended daily supervision of methadone during the first three months of treatment.

The Advisory Council on the Misuse of Drugs re-iterated the recommendations in 2000. ‘The key issue is supervised dosing at the beginning and during the early stages of treatment. Supervision should only stop when the clinicians involved are certain that an individual is taking the methadone properly and safely. Supervision guarantees that the methadone is being taken as directed by the person for whom it has been prescribed. When you are sure someone is well, compliant and really stable, you can taper and then eventually stop the supervision’, says Professor Strang.

Supervised dosing progressively became routine. A decade after the first survey, our researchers at the NAC surveyed high street pharmacists again: they found that 36 per cent of all methadone prescriptions were supervised, and many of the remaining prescriptions would have been for people who were past the early stages of treatment.

Professor Strang and colleagues calculated that the introduction of supervision saved an estimated 2,500 lives in England between 2001 and 2008.

He adds, ‘the considered judgement made by policy-makers in the 1990s to introduce supervised treatment has proved itself to be the right judgement call. As a result, we now have much safer methadone treatment programmes.’

Research led by Professor John Strang

REFERENCES

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