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John Latham and **Robin Fisher** explain their contrasting positions

Should we prescribe metha

'Yes!' **John Latham** is a GP trainer in inner-city Dublin

Heroin addiction is a chronic disease with associated morbidity and mortality as well as forensic, public health and social consequences. Methadone has been increasingly used since Dole and Nyswander's original trial in 1965.[1] Its half-life is far longer than that of heroin, being 24 and two hours respectively. It can be taken orally rather than smoked or injected like heroin. The fact that methadone itself is addictive is certainly a negative side effect but I believe that this factor is far outweighed by the positive therapeutic effects seen every day in our patients.

Evidence based therapeutics

Methadone is a rigorously well-tested medication that is safe and efficacious for the treatment of opioid withdrawal and dependence… Heroin releases an excess of dopamine in the body and causes users to need an opiate continuously occupying the opioid receptors in the brain. Methadone occupies these receptors and is the stabilizing factor which permits heroin addicts on methadone to change their behaviour and cease heroin use.[2]

Used carefully for maintenance or detoxification, methadone satisfies all the criteria for a good and evidence-based therapeutic intervention. The literature is vast but I recommend Ward et al's book on the subject.[3]

Cessation of heroin use. All other positive effects flow from ending reliance on a street drug that must be administered every few hours and requires total life concentration on obtaining the next fix.

Crime reduction. Several randomised controlled trials (RCTs) support the view that methadone maintenance treatment reduces heroin use and crime.[4] This is very evident amongst my inner-city Dublin patients. The danger of street sale of prescribed methadone can be minimised by careful protocols and dispensing systems such as supervised ingestion.

HIV reduction. Reviews are consistently concluding that methadone maintenance treatment effectively reduces HIV spread and injection-related behaviours known to transmit it.[5] I watched many young patients develop HIV and die in the 1980's and early 90's; now, I feel strongly about the need for interventions to prevent this dreadful infection.

Holistic health improvement. This is very evident in patients treated with methadone in properly run GP led treatment programmes. All other health uptakes are improved: women's health; diagnosis and treatment of hepatitis C and HIV and vaccination for hepatitis B; diagnosis and treatment of mental health problems such as depression as well as improved child health and primary infant immunisation uptake. These are all spin-offs of primary care methadone treatment. Although it is difficult to quantify in the literature, I can report from my own practice that routine and opportunistic health care is almost non-existent in the drug injecting population but very much improved for those who visit my surgery 52 times a year for our methadone programme.

Spiritual benefits. These are readily apparent in many patients on methadone treatment. Those injecting or smoking heroin are rarely in a position to contemplate anything but their immediate physical craving. They cannot easily identify the spiritual void in their lives. There is a deep spiritual dimension to every case of addictive behaviour. In my role as a director of Teen Challenge Ireland, I am aware that some addicts can become drug free without medication by the Holy Spirit's power as they repent and believe in Jesus.[6]

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Conclusion

I feel duty bound to offer a scientifically proven and ethically approved intervention for a chronic, potentially fatal illness that is very prevalent in the community for which I work. In my opinion, I would have been guilty of medical negligence if I had not gained training in methadone treatment and offered it to appropriate patients.

REFERENCES

1 Dole V et al. A medical treatment for diacetylmorphine(heroin) addiction: a clinical trial with methadone hydrochloride. *Journal of the American Medical Association* 1965; 193:80-84

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3 Ward J et al. *Methadone maintenance treatment and other opioid replacement therapies*. Amsterdam: Harwood Academic, 1998

4 Marsch L. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis. *Addiction* 1998; 93:515-532

5 Sorenson JL et al. Drug abuse treatment as an HIV prevention strategy: a review. *Drug and Alcohol Dependence* 2000; 59:17-31

6 *www.teenchallenge.com*

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done for drug addicts?

'No!' **Robin Fisher** is a prison doctor in Derbyshire

Like teenage sex and smoking, drug addiction is not a medical condition, though its effects too often are. It belongs in a grey underworld of degradation and corruption, not masquerading in the surgery as a disease. Addiction is just one of the areas invaded by the medical model, which is all too eagerly accepted by addicts themselves. 'I will be forced to take drugs if you don't give me methadone.' In other words, 'I am the victim of a disease for which you have the cure and you are responsible.' If we treat addiction as a disease then we turn a moral problem into an illness and transform addicts into victims, barely responsible for their own lives.

As an inner-city GP, I prescribed methadone for four years. In my experience, it almost invariably fails to do anything for drug users. Addicts use it to buffer their habits, cutting down on heroin costs. Morphine substitutes do not really help addicts control their habit and do not break the ingrained behavioural pattern of escaping to drugs in times of stress and crisis.

Morphine substitutes are used because coming off drugs, the 'detox', is seen as a horrific experience that we cannot expect addicts to endure. Yet, coming off drugs is not the real issue, nor is it half the horror that it is imagined to be. Many long-term addicts have 'turkeyed' on a number of occasions. Staying drug free is the problem. How often have we seen addicts come off drugs and then fall back again?

The cardinal aim of rehabilitation for substance users must surely be a substance free life. I firmly believe that we cannot fight substances with other substances. In the prison where I work, the detox regime is a complex protocol involving four different drugs that are issued daily. One of these, buprenorphine, has a high street value and is escaping onto the prison drug market. The same drug is getting into the prison from the surrounding area as the local GPs are prescribing it. At the clinic where these substances are doled out, it is only too obvious that becoming drug free is the last thing on the recipients' minds as they argue aggressively and noisily about the dose regime that they agreed to only a day previously. Some try every way of avoiding swallowing the drugs so that they can go on to sell them. I am so grateful that I am not involved in this professionally disreputable fiasco.

The use of opiate substitutes may also disguise the poverty of rehabilitation programmes where

> THE AIM OF REHABILITATION FOR SUBSTANCE USERS MUST SURELY BE A SUBSTANCE FREE LIFE

the workers have little to offer in the shape of transformed and attractive lifestyles. It replaces what should be of the utmost importance in drug rehabilitation: the devoted care of people committed to rehabilitating drug users, themselves genuinely committed - with all the likely ups and downs - to becoming drug free. The reputed horrors of 'rattling' become very manageable or disappear altogether when highly committed people give withdrawing addicts a constant ministry of prayer and care. This needs to be within the context of an ongoing programme of support as they attempt very difficult personal changes. It is here that Christians have so much to offer as we have the Gospel!

Harm reduction programmes are prevalent throughout medicine. In the context of drug addiction, harm reduction is based on the addict's choice to remain an addict and we are colluding with him or her if we are drawn into it.

Walk the extra mile

Prescribing methadone by itself is a fairly meaningless exercise. It may well play a part in a whole person approach but the most important thing to give each patient is self-respect. 'Love your neighbour as yourself' (Matthew 19:19). If Jesus can see the best in the worst sinner, cannot we, his followers?

One of my patients dealt £2,000 of heroin each week in order to feed his habit. He had refused to countenance withdrawal. Suddenly he stopped using and dealing and got a job. Much later I asked him what had changed him. He replied, 'You did. You were the first person in my life who treated me with respect.'

We should not prescribe methadone to our patients *unless* we are prepared to walk that extra mile with them.

John Geater was a GP in Hastings and is now Director of PRIME

What position do you take? Is there a particular issue that you would like featured in Head to Head?

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