

Re: Promoting abstinence for drug users is about saving money not science

Rapid Response: 25 March 2013

While agreeing with Dr Luty on the need for accessible opioid maintenance treatments, he is unduly pessimistic regarding long-term abstinence. Good research shows that, as with tobacco and alcohol, about 4% of addicted individuals become abstinent each year, regardless of treatment (ref 1). By ten years over a third of opioid dependent citizens have achieved abstinence. The remainder are mostly on opioid maintenance treatment, one of the smallest yet most efficient parts of any health system, requiring little more than a GP and an experienced pharmacist. This saves lives and reduces many other negative aspects of addiction (ref 2).

Those who are denied appropriate treatment have a mortality rate up to 7 times higher than those in treatment (ref 3). This is especially important on prison release where automatic access to treatment should be the dual responsibility of the health and custodial systems.

The arbitrary rules of the UK NHS quoted by Dr Luty should not distract us since dependent pharmacotherapy patients are not fundamentally different from others with chronic conditions. New and unstable patients will require frequent reviews while others can be seen just a couple of times per year to ascertain progress and decide on any changes in doses, medication combinations and/or ancillary services.

Another disadvantage of the British system is that buprenorphine, the only evidence based alternative to methadone, is still not available in many health regions largely due to the high cost of this drug.

Opioid maintenance is not rocket science, yet for decades the UK had the twin problems of inadequate dose levels and almost non-existent formal dose supervision (ref 4). This so limited the positive outcomes that many now express doubts about the benefits of the treatment as it is used in the UK. Current and past leaders of the UK medical profession in the dependency field must take responsibility for these deficiencies, now causing politicians to dismantle an essential intervention which is implemented in almost every western country and now importantly in China.

Andrew Byrne ..

Ref 1 Thorley A. Longitudinal Studies of Drug Dependence. In: Drug Problems in

Britain: A review of ten years. Eds: Edwards G, Busch C. 1981, Academic Press. p162

Ref 2 Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Cochrane Review) The Cochrane Library, Issue 1 (2005) Chichester, UK: John Wiley & Sons, Ltd

Ref 3 Peles E, Schreiber S, Adelson M. Opiate-Dependent Patients on a Waiting List for Methadone Maintenance Treatment Are at High Risk for Mortality Until Treatment Entry. J Addict Med 2013 Mar 20. [Epub ahead of print]

Ref 4 Strang J, Manning V, Mayet S, Ridge G, Best D, Sheridan J. Does prescribing for opiate addiction change after national guidelines? Methadone and buprenorphine prescribing to opiate addicts by general practitioners and hospital doctors in England, 1995–2005. Addiction 2007 102:761-770

Competing interests: Dr Byrne runs a private addiction out-patient clinic.

Andrew Byrne, Addiction physician

Private practice, 75 Redfern St, Redfern, NSW 2016 Australia