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UK Pharmacies Offer Sense of Normalcy for Methadone Patients

Country's high treatment engagement rates show approach's success

Overview

Methadone is an effective medication, approved by the Food and Drug Administration, to treat opioid use disorder (OUD). Research shows that it can reduce overdose deaths and help people stay in treatment.[1] In the U.S., the medication is heavily regulated and available only at opioid treatment programs, health care facilities governed by federal and state laws. These programs subject patients to punitive rules—such as limits on take-home doses and frequent urine screens—borne of stigma surrounding addiction and the medication itself.[2]

Other countries approach methadone treatment differently, often making it easier for patients to access lifesaving care while still fulfilling obligations under international drug control treaties.[3] These international approaches can shed light on ways for policymakers to improve OUD treatment in the U.S.

The United Kingdom's approach to methadone treatment

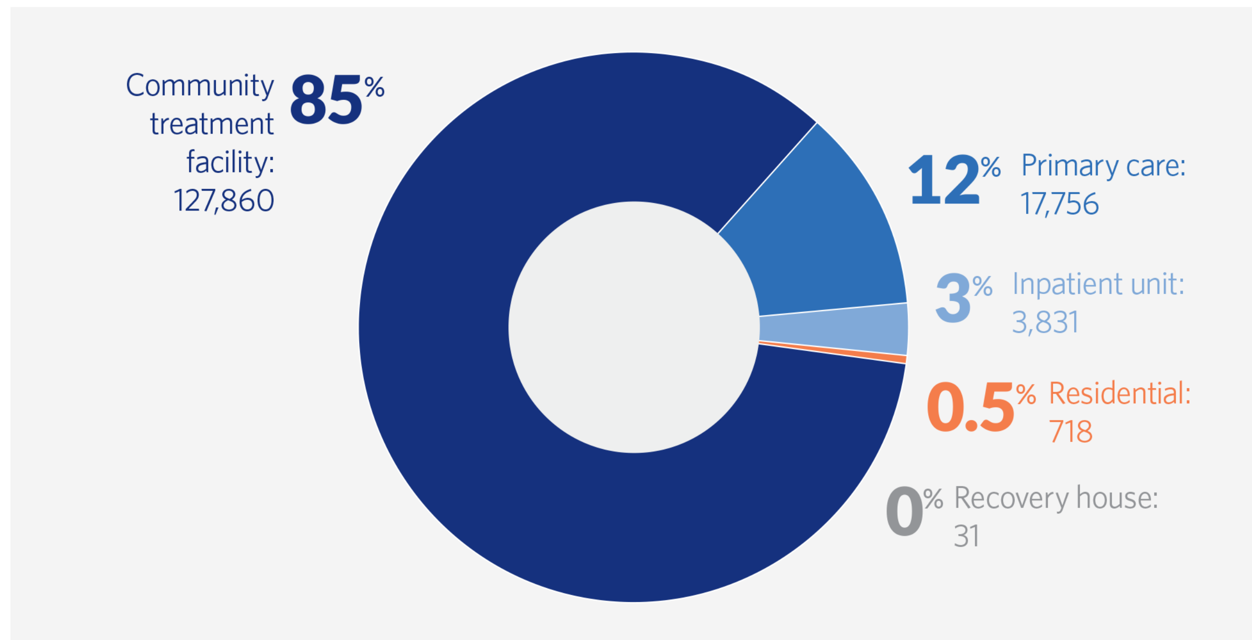
In England, the largest country in the UK, more than half of all people with OUD are engaged in treatment.[4] Nearly all of these individuals receive a medication for opioid use disorder (MOUD)—methadone, buprenorphine, or naltrexone.[5] By comparison, in the U.S. less than 30% of people with OUD are engaged in care.[6]

One factor helping so many people in the UK to access treatment is that throughout the country, people with OUD can get their publicly funded methadone at a retail or community pharmacy—where pharmacists can observe dosing and provide take-homes (medication doses for home use). Most of the MOUD prescriptions are written by community-based addiction treatment providers, although general practitioners are also legally allowed to prescribe the medication, and some do.[7]

Figure 1

Most MOUD in England Is Prescribed in Community Addiction Treatment Settings

Treatment data from April 1, 2020–March 31, 2021



Note: Data includes prescriptions for all forms of MOUD: methadone, buprenorphine, and naltrexone.

Source: UK Office for Health Improvement and Disparities, "Substance Misuse Treatment for Adults: Statistics 2020 to 2021," Table 9.1, https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021

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Treatment settings and guidance

Prescribers and dispensing pharmacists in the UK follow guidance from a publication known as "The Orange Book," published by the Department of Health and Social Care, which lays out a set of standards for how to treat substance use disorders, including the use of medication. Among other topics, these standards include guidance on:[8]

- Assessing whether a patient is a good candidate for medication.
- Creating treatment plans in collaboration with patients, including services such as counseling.
- Sharing information about how the patient is doing through ongoing communication between the prescriber and community pharmacist.

In the UK, the standards are similar for both methadone and buprenorphine, and the use of either medication is known as opioid substitution therapy.[9] Any prescriber can write a prescription for methadone, and any pharmacist can fill it, without needing special certification or mandated training.

"The Orange Book" also provides guidance on how patients receive their doses. In the early stages of treatment, dosing is supervised—meaning that patients take the medication in front of someone, usually a community pharmacist. During that time, the pharmacist checks in with patients about their progress and health.

As patients progress in treatment, they can also pick up doses to take home. Unlike in the U.S., where there are strict guidelines about how long people must be in treatment before they can receive take-homes, "The Orange Book" allows providers to make individualized, clinical calls as to when someone is ready.[10] It also recognizes the importance of these take-home doses, noting that "long-term, daily supervised consumption would probably not be appropriate for a patient in regular, full-time work or education where supervision would be a clear barrier to retention in treatment and recovery."

Once patients are eligible for take-home doses, they can receive medication for up to one week at a time, although they may receive less, based on the prescriber's clinical judgment. Once patients are well-established in treatment, they also no longer have to take an observed dose when picking up the medication at the pharmacy.

These rules have changed over time. Before the 1990s, the UK had no rules about supervised consumption, and patients could receive up to two weeks of medication at a time.[11] These rules were changed due to concerns about methadone overdoses, and after the current rules were put in place, annual deaths in England due to methadone dropped from 20.9 per million prescribed daily doses in 1999 to 6.5 per million in 2008.[12] This equates to 171 methadone overdose deaths in 1999, and there was then a five-year gradual reduction to 71 deaths in 2003. These numbers increased to 187 deaths in 2008; however, authors note that this number was lower than the peak number of deaths in 1997.

Changes in treatment because of COVID-19

During the COVID-19 pandemic, a two-week supply was once again made available to patients on a temporary basis.[13] This flexibility has since been withdrawn. Limited research is currently available on the impact of these changes, but interviews suggest that patients valued the additional flexibility provided by more take-home doses.[14] Providers, meanwhile, had mixed views. Some favored the UK's exploring permanent changes to take-home rules because they saw limited instances of diversion, while others were more hesitant.[15] One factor that may influence future take-home policy is that the rate of methadone-related overdoses increased in England and Wales while extended take-homes were in effect, from 7 per million people in 2019 (407 deaths) to 12 per million in 2021 (663 deaths).[16] This is a stark difference from the experience in the U.S. and Victoria, Australia, where methadone overdoses did not increase with additional take-homes.[17]

Treatment outcomes

A review conducted in 2017 by Public Health England (then the national public health body) found positive results from the community pharmacy-based approach to OUD treatment, finding that:[18]

- Engagement in treatment with buprenorphine or methadone is associated with a reduced risk of fatal overdose and reductions in HIV/hepatitis C virus transmission.
- Retention rates at three and six months are comparable between the UK and studies published on care in the U.S., Thailand, and Hong Kong.

A cost-effectiveness study found that, compared with not providing methadone or buprenorphine, methadone treatment saves the UK £17,174 per person in treatment per year in societal costs by reducing patients' involvement in the criminal legal system and reducing drug-related crime victimization, although treatment at one year was associated with small increases in the use of health care resources, including primary care, emergency department visits, and inpatient hospitalizations.[19]

Patient perspectives

Although the research is limited, several studies looking at patient perspectives on methadone treatment in the UK find high patient satisfaction.[20] Being able to receive medication at a pharmacy—also known as a chemist—provides a sense of "normalcy," as illustrated by a quote from one study:[21]

> "To me—that is the norm. … I just went down to the chemist yesterday, just picked up my week's methadone, and it is funny really, I don't think anything of it."[22]
>
> Male patient in a rural UK community

Among people who receive their prescription from a general practitioner, patients value the ability to receive integrated care that addresses their substance use, and mental and physical health needs.[23]

However, patients are not fully satisfied with pharmacists supervising dosing. One study examined this aspect of care and found that although it was generally acceptable in the early stages of treatment, patients valued the ability to progress to unsupervised dosing.[24] One reason for this was the fear of stigma—a theme that came up in multiple studies of patient perspectives discussed here, and one that is commonly cited as a barrier to treatment in the U.S. as well.[25]

Conclusion

In the UK, government OUD treatment regulations that are limited in scope compared with the United States have resulted in a highly effective methadone delivery system in which most people with OUD access the medication through prescriptions from specialty community treatment providers while others seek care in a doctor's office. Efforts to reform methadone delivery in the U.S. can consider both types of providers so that people with OUD can potentially access care in the place that is right for them.

Endnotes

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