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### Multiple choice questions

- 1 The following are diagnostic features for substance dependence:**
- a compulsion
  - b withdrawal syndrome
  - c salience
  - d satiety
  - e tolerance.
- 2 Methadone maintenance:**
- a is less effective than detoxification
  - b should always be discontinued following continued illicit drug use
  - c should not usually be started at doses above 40 mg
  - d has been shown to be effective in randomised controlled trials
  - e is optimally effective with daily doses of 30 mg or below.

**3 Drugs commonly recommended to treat opiate addiction include:**

- a naltrexone
- b chlorpromazine
- c diamorphine
- d lofexidine
- e chlordiazepoxide.

**4 The 12-step approach to treat addiction:**

- a has been shown to be less effective than CBT-based methods
- b has a strong spiritual element
- c is universally effective for cocaine addicts
- d can be combined with motivational enhancement
- e remains the only effective relapse prevention strategy.

**5 Most research has shown the following addiction treatments to be effective:**

- a methadone maintenance
- b family therapy
- c needle exchange programmes
- d therapeutic communities
- e motivational interviewing.

#### MCQ answers

1	2	3	4	5
a T	a F	a T	a F	a T
b T	b F	b F	b T	b F
c T	c T	c F	c F	c T
d F	d T	d T	d T	d T
e T	e F	e F	e F	e T

## INVITED COMMENTARY ON What works in drug addiction?

Few psychiatric specialities attract so much attention from other authorities and the general public as drug misuse. It is one of the major social problems of our time, and causes great difficulties for those who have become addicted, those around them and the community at large – not least through the effects of drug-related crime. Whether treatment is effective is not a matter simply of academic interest, but one that must be critically and correctly analysed so that

the balance that society has to strike between enforcement, preventive measures and treatment can be fairly judged. There can be a tendency for clinicians to overstate the effectiveness of treatment, perhaps partly because of a humane concern that incarceration, for instance, might make matters worse for their patients. However, this temptation must surely be resisted, as the realities of ongoing drug use, even in the face of advice, are often all too

plain to see. I have encountered the unqualified slogan 'treatment works' in various settings, including lobbying to governments, but such overgeneralisation is unhelpful and detracts from the vital message that this is a field in which prevention seems decidedly better than attempted cure.

As ever, there is no substitute for a rigorous examination of the relevant evidence, and this is exactly what Dr Luty has provided for us in his review (Luty, 2003, this issue). He has analysed the evidence supporting or failing to support the range of pharmacological and non-pharmacological approaches in drug misuse in enough detail to comfortably guide trainees and generalists managing individuals with drug problems. In setting the context for pharmacological treatments, he makes the important observation that no psychotropic medications have yet been demonstrated to be effective in stimulant misuse, and in concentrating on opiates he reflects the inevitable focus of clinical drug services. With opiates, there is an undoubted physical dependence that can be managed with 'substitute' medication or other detoxification treatments, whereas in most forms of non-opiate misuse, reliance must be placed on psychosocial approaches, including systematic drug counselling, 12-step methods and residential rehabilitation. Luty correctly points out that the support for these from systematic studies is relatively weak, and indeed no treatments have an evidence base that compares with that for methadone maintenance therapy. Therefore, sceptics might observe that relapse rates are high with all treatments other than the approach of giving substitute medication long-term, and once again we must not be shy of acknowledging that backdrop when we examine the different studies.

Despite the consistent evidence that methadone routinely reduces various indicators of illicit drug use, the treatment does have some disadvantages, including its own addictiveness and the risks in overdose. Indeed, following much misuse, the medication policies have generally been tightened in recent years so that a high proportion of patients are required to take their methadone under observation in a pharmacy each day. This in turn imposes constraints on patients' lifestyles and, with such considerations in mind, it has been welcome that positive evidence in favour of alternatives to methadone has gradually accumulated. The partial

opiate agonist buprenorphine is safer and less addictive than methadone and is likely to prove more suitable for detoxification treatment. Lofexidine satisfactorily relieves opiate withdrawal effects, and in community treatment it is more advisable than its analogue clonidine, because reduction in blood pressure is less marked. The position regarding the opiate antagonist naltrexone, which is used in relapse prevention, is interesting as the evidence-based reviews are less encouraging than the opinions of many clinicians who routinely use this treatment after detoxification. Luty makes the pertinent point that naltrexone has been at a disadvantage in some studies by being offered as a medication that patients might select when they could also choose methadone maintenance, whereas in practice the two treatments tend to be given to individuals at opposite ends of the motivation spectrum.

Motivational interviewing is an important psychological treatment, and other specific behavioural approaches such as contingency management and cue exposure have shown benefits in drug problems that are highly resistant to pharmacological methods, notably cocaine misuse. Finally, given that the most controversial policies attract the most media attention, it is not surprising that there has been recent publicity about the prescribing of diamorphine itself to heroin addicts, following trials in mainland Europe. This touches on the limitations of methadone, as some patients manifestly cannot adjust to its non-euphoriant effects, but diamorphine is likely to remain suitable for only a minority of users, partly because a satisfactory non-injectable pharmaceutical preparation has not yet been developed. Methadone and buprenorphine at least have the advantage that they are oral and sublingual treatments, and it will remain a priority to remove many users from injecting because of the specific hazards associated with that aspect of drug-taking.

## Reference

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