CAUTION: This is the text underlying the published version of the same 'Nugget'. It may not incorporate late revisions and corrections. Neither the text nor the citations were finalised for publication so may be inconsistently presented and sometimes take the form of notes rather than polished text. It is offered as a source of additional information and citations but should not be relied on, especially when it departs from the published version, for which click HERE. For further information or to comment on this draft contact editor@findings.org.uk.

© Drug and Alcohol Findings 2006. Permission is given to distribute this document unamended electronically or on paper or to incorporate passages in other documents as long as the source and copyright owner are acknowledged including the web address http://findings.org.uk.

Nugget 15.6

Stripped down methadone prescribing better than leaving patients waiting

Findings Patients who have to wait to join a fully-fledged methadone programme feel better, use drugs less and are more likely eventually to enter the programme if offered basic substitute prescribing during the waiting period.

As long as patients are waiting to enter a comprehensive programme, and every dose is supervised, US regulations excuse 'interim' methadone programmes from providing regular counselling for up to four months. For the first time a clinic in Baltimore trialled a regime embodying these regulations.

Of 319 applicants on a waiting list of at least two weeks to start the clinic's usual methadone programme, 199 were randomly allocated to interim prescribing from a mobile facility near the main site. After a brief induction and medical examination, prescribing started the following day. Remaining patients were instead placed on the usual waiting list and had no further contact with the clinic until a place became available. All the patients were told how to apply to other local clinics.

The interim programme began with a dose of 20mg rising daily to an intended 80mg subject to individual adjustments. Though it entailed daily contact with clinic nurses, no counselling was provided except in a crisis or to consider patient requests to exceed 80mg. Only three patients sought and received such counselling.

Patients attended over 9 in 10 of their scheduled visits to the interim clinic and just 16% who started this treatment dropped out during the four months without transferring to an alternative programme. During this period, drug use overall (including drinking) fell significantly more among the interim patients, particularly heroin use. Whilst waiting-list patients continued to use heroin nearly every day, at follow-up (either on entry to a mainstream methadone programme or at the end of the four months) interim patients said they used on average just once a week, a drop broadly confirmed by urine tests and reflected in dramatic reductions in spending on drugs and in illegal income not seen in the waiting-list patients. By the

end of the four months, three quarters of the interim patients had started a fully fledged methadone programme (most at the study's clinic) compared to just a fifth of waiting-list patients.

In context None of the eligible patients refused to join the study, a sign of the attraction of the chance to gain immediate access to methadone. However, as well as methadone, they were guaranteed a place in the main programme after four months if they had not yet found an alternative. This might itself account for why so many more were able to start fully-fledged treatment.

That this was not all there was to it is suggested by the most relevant earlier study. This did not offer a guaranteed place yet still found that bridging the waiting period with a (more or less) methadone-only stop-gap cut heroin use in half compared to simply being placed on a waiting list.[1] In this study, too, entry in to treatment was improved without adversely affecting subsequent retention.[2] Similarly, in Oslo a buprenorphine-only bridge for patients awaiting entry to the methadone programme cut drug use and improved well-being compared to a placebo, and more patients stayed in treatment, though eventual entry rates to the methadone programme seemed unaffected.[3]

US and UK studies have shown that accelerating entry to methadone programmes greatly increases uptake without adversely affecting later retention or outcomes, exposing delays as a barrier to treatment, not a filter to exclude the unmotivated or unpromising.[4 5 6 7] British services have successfully countered the effects of delay by arrangements such as interim prescribing from GPs.[8] In one of the few direct tests of interim arrangements in the UK, a Scottish clinic overwhelmed by referrals introduced a programme which streamlined treatment entry and provided psychosocial support only when the client sought it.[9] 60 of the 101 patients were discharged to further treatment but many preferred the less demanding regime, resulting in longer than expected stays before transfer. Whilst in the programme patients reported dramatic reductions in injecting and decreases in crime and depression.

Though the featured study concerned interim entry arrangements, others have trialed stripped down methadone programmes as an alternative to more comprehensive provision. For low-risk patients only, an English service replaced key-working with fortnightly drop-ins during which clients might be counselled by any member of the team.[10] Capacity increased yet patients were satisfied with the service and well retained. Without such selection, and if the caseload is severely problematic and unstable, such arrangements have proved untenable because crises demand repeated intervention[11 12] and despite costing less, cost-effectiveness in terms of $ per abstinent patients deteriorates.[13] Whether extra services create substantial extra gains will depend partly on how well targeted and adequate those services are – little added value can be expected from adding irrelevant or poor provision.[14 15] An alternative to a stripped down programme is to allow patients to choose whether and when they want counselling. In Toronto this and other relaxations in the regime increased capacity without affecting retention or on-top drug use.[16 17]

Practice implications Subject to sufficient assessment and monitoring to ensure clinical safety, starting prescribing in the absence of regular counselling or other

psychosocial supports is preferable to simply leaving patients waiting, even for a few weeks. Patients reduce their drug use, health risks and criminal activity, and more go on to enter the main programme. For some patients, little more may be needed and such programmes can form a longer term alternative to more intensive support. These patients might be identified by how well they do on the interim programme. However, it also clear that multiply problematic clients benefit from regular counselling and well targeted ancillary services, and without these will suffer repeated crises, in the end demanding more intensive and expensive intervention. Cost-effectiveness is probably maximised by making more intensive and extensive services *available* for those who feel they need them, or where referral to such services seems advisable. NTA guidance defines the start of treatment as the date methadone is first dispensed, meaning that so long as care planning has occurred,[18] interim arrangements such as those trialed in the featured study not only benefit the patients, but can help services meet both waiting list and recruitment targets.

Featured studies Schwartz R.P. *et al*. "A randomized controlled trial of interim methadone maintenance." *Archives of General Psychiatry*: 2006, 63, p. 102–109.

Contacts Robert P. Schwartz, Friends Research Institute, Inc, 1040 Park Ave, Suite 103, Baltimore, MD 21201, USA, rschwartz@friendssocialresearch.org.

Nugget **1.4** • Nuggettes 1 issue 12, 2 issue 11

Appendix to Nugget 15.6

NB This appendix is not nor is it intended to be a comprehensive review of the literature but to be sufficient to support the statements made in the main text.

About the study

None of the eligible patients refused to join the study, itself a sign of the attraction of the chance to gain immediate access to methadone. Few subjects were lost to the study for other reasons, suggesting that the results were not due to the recruitment of an atypical set of patients.

Patients in the interim programme not only had this to sustain them during the waiting period but also were guaranteed a place at the end of it. How much each of these features contributed to the improved entry rate is unclear. It is possible that more waiting-list only patients would have entered treatment had they too been guaranteed a place, and that some failed to do so simply because they could not find a slot.

Over 8 in 10 of the interim patients simply transferred to the study clinic's usual programme at the end of their four months of interim prescribing, a result which suggests that either they were in no hurry to access counselling, or they were unable to secure alternative placements. If the latter then the same shortage of places might account for why so few waiting-list patients entered treatment during the four months, if the former, then together with the generally impressive outcomes, one has to question the added value of counselling.

The study does not report how many of the waiting list patients were offered a place at the clinic before the end of the four months. If few were, then scarcity of treatment slots becomes a likely explanation for the findings. If instead typically they were offered a place, then withering of motivation in the face of delay becomes the more likely explanation.

British studies

In England faced with caseload which made traditional one-to-one key working unsustainable, a drug service divided its clients in to high and low threshold.[19] The latter were uncomplicated clients (eg, no children or mental illness) who have been in treatment for over six months and have been assessed by the team to be on an appropriate level of methadone. Key working was retained for high threshold clients but low threshold clients instead asked to attend the service on a drop-in basis between 09.00 a.m. and 12.30 p.m. on Tuesday mornings. Their methadone prescriptions were adjusted so that they were required to come in on this day to see a member of staff. The group were divided roughly in half with 16 clients attending one week and the remaining 18 clients the next week. Instead of seeing a designated worker they saw a member of the clinical team. The staff report that "100% of clients stated that they preferred a drop-in approach. They felt that they could discuss issues with all of the workers and were satisfied with their methadone dosage ... The team's reaction to the service was also positive; this model of working was safe and efficient ... The clinicians believed that the screening and selection process for clients enabled them to use this model of brief contact with clients safely

… The best sign of success is the 100% retention rate to the service over three months."

Long waits for methadone prescribing meant twice as many patients dropped out at a clinic in south London. For the study 182 patients attending for assessment were randomly allocated to a normal waiting period before treatment started (four to 12 weeks) or to accelerated entry (about two weeks).[20] Almost twice as many (41% v. 23%) of the normal entry patients did not start treatment. Of those who did start, slightly more rapid entry patients later dropped out but this effect was marginal, suggesting that rapid entry enabled more referrals to engage with treatment. Previous work at the same clinic had shown that while waiting for treatment to start, patients did not reduce their heroin use, but that this fell rapidly after entering treatment.[21] The implication of the two studies is that the longer someone waits, the less likely they are to start treatment, and even if they do start, they will have spent longer at risk from dependent heroin use.

In contrast, in a national sample of methadone prescribing services in England, waiting longer for an assessment did not mean more people failed to turn up, and waiting longer for treatment entry was unrelated to whether patients were still in treatment three months later.[22] However, this study simply recorded waiting times rather than deliberately changing them. Many other influences could have affected both waiting times and treatment uptake, obscuring the effect of the former on the latter. For example, most services tried to arrange interim prescribing by GPs and they may have also tried to get some types of clients in earlier than others.

A prescribing service in Scotland found itself overwhelmed by referrals and unable to chase up people who failed to attend for appointments.[23] The solution was to introduce a 'low threshold' methadone programme which, as well as streamlining treatment entry, provided counselling and other forms of help only when the client actively sought them. Doses started at around 40mg and increased to an average of about 60mg before discharge. At first patients had to attend five times a week for their prescriptions to be dispensed but later this was restricted to an initial phase after which weekly attendance was required. The 'chaotic' caseload was typically unemployed and recently or currently homeless and injecting several times a day. The effect was to widen treatment access, the impact on retained patients was beneficial, and many went on to the full prescribing programme or to GPs. The outcome data came from MAP questionnaires applied at intake and 8 weeks by clinical staff so are vulnerable to over-optimistic reports of progress. 69 of 101 patients were retained long enough to complete the 8-week follow-up. They reported dramatic reductions in injecting from four times a day most days to seven days out of 30 and just once on each of those days and the % sharing works in the past month fell from 15% to 4%. The % involved in crime fell significantly and depression receded. 60 of the 101 patients were discharged to further treatment. Discharged patients stayed for typically 4.5 months, longer than envisaged, partly because many did not want to transfer to the more comprehensive prescribing programme.

UK drug service clients value counselling and feel it is effective but generally do not find prescribing services meet their needs in this regard.[24]

Other studies

In the early 1970s in Chicago a "pre-treatment" programme was established for patients awaiting entry to Chicago's methadone programmes. There is no formal report on the evaluation which compared patients who opted for and entered this service versus those who waited in the usual way.[25] The pre-treatment service consisted almost entirely of doses of methadone. Urine specimens were collected three times a week and patient filled out some forms weekly reporting on his activities. "During a 16-week study of pre-treatment patients, it was found that there was no improvement in employment status, but there was a substantial decrease in narcotics use as well as a substantial decrease in self-reported illegal activity. The pre-treatment patients reported less than half the amount of illegal activity as those who were simply put on a waiting list. The most encouraging finding of the study was that when openings occurred in regular treatment units, seventy percent of the pre-treatment patients accepted, in contrast to only 28 percent of those who were left on the waiting list."

Around 1970 a US methadone programme abandoned the attempt to allocate half its patients to a methadone-only regime and allowed all patients on-request access to a range of psychosocial services.[26] Despite the contact entailed in daily supervised consumption and high doses of methadone (80–120mg) "many addicts .. exhibited a patent need for other help" once the honeymoon period of the start of prescribing (about four weeks) had passed. Patients all had repeatedly relpased to heroin use following withdrawal and had multiple felony convictions but were free of psychosis and other drug dependencies. The authors felt that the changes in their lives force by blockade levels of methadone required substantial readjustments on the part of the patients resulting in a need for crisis intervention which 79% accessed.

In February 1987 a clinic that provided initial medical evaluation, methadone, and AIDS education, but did not include formal drug abuse counselling or other social support services was established in New York City.[27] Only minimal ad-hoc counselling and other on-site services were provided but patients did have to attend five days a week for methadone consumption to be supervised by a nurse. Doses started at 20–30mg and rose slowly to about 80mg, individually adjusted. A sample of 301 volunteer subjects recruited from the waiting list for treatment in the Beth Israel methadone programme were randomly assigned to immediate entry into the interim clinic or one of two control groups who waited (at the time waits averaged three months) for entry to the methadone comprehensive programme. Each group had an equal chance of entering or being transferred to this programme when a slot became available. Unlike the featured study, the interim patients were not guaranteed a place but they did have regular quasi-clinical contact; like the interim programme patients, one of the control groups entailed fortnightly urine tests and follow-up questionnaires which the patients may have seen as part of the treatment programme, a greater degree of attention than is typical of waiting lists. However, since the analysis focused on the first month of the wait normally only one or two such contacts would have occurred. The other control group did not have these contacts but recruitment to this group ceased (and it was dropped from the analysis) when it was clear that people were not prepared to join a study which gave them a two in three chance of not gaining quicker access to methadone. At the same time,

the time spent on the waiting list was limited to one month before patients transferred to the interim programme. Over this month urinalysis follow-up data showed a significant reduction in heroin use in the experimental group (from 63% positive at intake to 29% positive) with no change in the control group (62% to 60% positive). No significant change was observed in cocaine urinalyses (approximately 70% positive for both groups at intake and follow-up). 16 months after the interim programme had started a higher percentage of the experimental group were in treatment (72% vs 56%). The conclusion was that compared to waiting list, limited services interim methadone maintenance can reduce heroin use among persons awaiting entry into comprehensive treatment and increase the percentage entering treatment.

After the initial research reported above the interim clinic continued as routine practice until 1992. Patients could opt for this while waiting for usual treatment but the interim clinic itself became full and operated a waiting list though typically shorter than that for comprehensive treatment. A later study based on clinic records for all patients admitted in 1990 and 1991 showed that retention to one year was only slightly and non-significantly worse among patients who entered treatment via the interim clinic, despite comparable caseloads.[28] The two groups did not differ with respect to demographics. The three-, six-, and 12-month retention rates of patients first admitted to the interim clinic were 78%, 69%, and 62%, respectively. The three-, six-, and 12-month retention rates for patients admitted directly to a traditional methadone clinic were 84%, 76%, and 68%, respectively. The interim clinic six-month retention rate of 69% was better than 16 out of 21 programmes reported on by the US GAO in 1990.

In Oslo researchers tried prescribing buprenorphine to tide over patients awaiting methadone treatment. This is the abstract of the study:[29] "Aims To evaluate whether buprenorphine, even without additional control and psychosocial treatment and support, alleviates the problems faced by patients waiting for medication assisted rehabilitation (MAR). Design A randomized, double-blind, 12-week study of Subutex ® versus placebo without additional support as an interim therapy. Participants One hundred and six patients, 70 males and 36 females, waiting for MAR in Oslo. The average age was 38 years with an average history of heroin use of 20 years. Fifty-five patients were assigned to buprenorphine and 51 to a placebo. Intervention Subutex ® or placebo sublingual tablets were given under supervision in a daily dose of 16 mg with the exception of a double dose on Saturday and no dose on Sunday. Measurement Retention, compliance, self-reported drug-abuse, wellbeing and mental health. Findings The average number of days of participation was significantly higher in the buprenorphine group, 42 (median: 29) compared to 14 (median: 11) for the placebo group ($P < 0.001$). The retention of patients after 12 weeks was 16 patients in the buprenorphine group and one patient in the placebo group. The buprenorphine group had a larger decrease in reported opioid use ($p < 0.001$) and in reported use of other drugs, tablets and alcohol abuse ($p < 0.01$). The group also showed a stronger increase in wellbeing ($p < 0.01$) and life satisfaction ($p < 0.05$). None of the participants died. Conclusion The patients waiting for MAR benefited significantly from the buprenorphine as an interim therapy according to retention, self-reported use of drugs and wellbeing. However, the patients had difficulties in remaining in treatment over time without psychosocial

support." The study was initiated in the face of a substantial waiting list of often severely affected patients awaiting the comprehensive services mandated by the state. Following the 12 weeks of the study all patients were offered buprenorphine while they awaited entry to the full programme. The placebo group effectively started the study with a buprenorphine detox, reducing from 4mg to 0 in nine days. It was immediately after this that nearly all the drop-out occurred. Most patients guessed correctly whether they were on placebo or active doses so the very low retention in the placebo group may reflect disappointment. 99 of the 106 patients came back to the clinic after 12 weeks to start (or continue) interim buprenorphine treatment, indicating that whilst nearly all the placebo patients did not find it worthwhile to attend while on placebo, nearly all returned when they knew active medication would be initiated.

The impact of accelerated entry

Despite a powerful pharmacological inducement, even prospective methadone patients are deterred by long waits. In this modality rapid initiation must be balanced against the risks of prescribing inappropriately or excessively, risking overdose. But within the limits of clinical responsibility, paring pre-treatment delays and 'hurdles' to the minimum increases treatment entry rates without adversely affecting retention or outcomes, exposing delays as simply a barrier to treatment, not a filter to exclude the unmotivated or unpromising.

One US service used extra funding to expand capacity and reduce waiting times from first contact to intake from 40 to 14 days, and to cut the intake process from two weeks to two days.[30] The number of people requesting intake appointments tripled from 35 to 100 per month yet the percentage who kept appointments rose from 33% to 54%, without affecting longer term retention. Another effect was to open up the programme to more socially excluded and severely dependent clients, perhaps the ones least able to hold on for a slot.

In Texas a methadone programme randomly allocated applicants to its usual two-week comprehensive assessment, or instead started patients on methadone within 24 hours of initial contact.[31] Only 4% of these patients failed to make it to the first dose compared to 26% after extended assessment, yet over the next year just as many stayed in treatment and they did just as well in terms of illegal drug use, HIV risk and social reintegration. The service achieved this result by deciding which assessment elements were essential to determine whether the applicant was eligible for methadone and deferring the rest until after they had started treatment.

The message is an old one. Over 30 years ago a methadone service in Philadelphia tried replacing its two-stage intake procedure (patients had to return the following day for a series of appointments before receiving methadone) with a one-stop, walk-in procedure in which initial assessment and the first methadone administration were completed seamlessly on the same day.[32] Two months later about 55% of the one-stop patients were still in treatment but just 30% of those made to return, a difference probably due to patients failing to return after the first contact.[33] After this the two sets of patients dropped out at roughly the same rate. The result was that at five months still over twice as many of the same-day patients were in treatment. As in Texas, the method was to defer inessential assessment elements

until after prescribing was initiated and results were achieved through increased flexibility rather than greater resources.

Are cut-down services a viable alternative to more comprehensive programmes?

What happens when you loosen the reins in a methadone programme, streamline intake, let the patients decide whether they want counselling, give them a greater say over doses, cut down on urine tests, allow more take-home doses, no longer treat continued illegal drug use as a disciplinary issue, accept goals short of abstinence from illegal drugs, and have more doctors in the area to whom you can transfer longer term patients? The first thing is that you can treat more patients, the reason why from 1995 this package was introduced at a clinic in Toronto, Canada. Patient numbers doubled and the waiting list was eliminated.[34] The other effect was to create space for groups beyond those prioritised due to special needs such as pregnancy and HIV infection. By the end of the expansion, on average patients were less socially marginalised, but these differences were not huge. More noticeable was that people addicted to opioids other than heroin and who did not inject (or more often, had stopped) now accessed treatment, though in other ways (duration of addiction, other illegal drug problems) they changed little. Retention in methadone treatment and its impact on illegal drug use also altered little.[35] This stability held even when like-for-like (eg, injecting heroin users) patients were compared. Allowing patients to set their own pace in reducing illegal drug use did not mean more used 'on top', on average they attended as many therapy sessions as when these were mandatory, and generally there were no signs that widening access and relaxing the regime had attracted less motivated patients. Confrontations over continued illegal drug use could give way to potentially more productive interactions.

A trial by a research group in Philadelphia randomized patients to one of three conditions:[36]

- minimum methadone services, minimum dose of 60mg without counselling (though counsellors did maintain monthly contact) or extra services (MMS);

- standard methadone services, a minimum dose of 60mg with regular counselling once a week to begin with then adjusted to the stability of the patient but no extra services (SMS); and

- enhanced methadone services, a minimum dose of 60mg with counselling as above but also extra services including regular medical and psychiatric care, social work assistance, family therapy and employment help on site(EMS).

The counselling in the last two conditions actively targeted behaviour change. After 24 weeks all patients were to revert to usual care. 92 patients completed at least 2 weeks of the study and were considered to have participated sufficiently in treatment to be included in the analyses.

Patients were typical of the area's caseload – black single men with extensive criminal histories and most with histories of serious psychiatric disorder who had been using opiates for 11 years – not the best candidates for low intensity care.

While at the end of 24 weeks the patients in the minimum service group did show

reductions in their drug use, the addition of basic counselling was associated with better outcomes and the addition of on-site services led to even better outcomes. Across 90% of patients in the minimal contact group required at least one emergency medical or social service intervention and 69% (all in the first 12 weeks) had to be transferred out of the study's interventions to usual care (similar to the study's standard treatment) after health emergencies or when urine tests revealed "unremitting" continued heroin or cocaine use. 41% of the SMS and 19% of the EMS groups met the criteria for transfer but were not transferred because they were already in treatment of usual-care standards. From the start opiate and cocaine use confirmed by urinalysis was greatest in the minimal care group and did not fall from the starting % of around 60% positive for opiates. Reduction in opiate use were greatest in the enhanced services group. Over the last month of the (approx) six months of the study, the few (10) patients who remained in the minimum methadone services condition had significantly reduced their opiate use from 14 to 3 days a month, their ASI drug problem score had also feel significantly. Though three were now no longer using heroin or cocaine this was not a statistically significant change and nor were any of the other measures of medical legal psychiatric employment or drug outcomes significantly changed, some probably because the numbers were small (involvement in crime was substantially reduced) others because there was simply no noticeable improvement (eg, psychiatric problems). The other two groups had made similar reductions in opiate use and also reduced cocaine use and their involvement in crime and showed improved psychiatric functioning, the latter significantly so in the enhanced services group. There were no significant improvements in employment or medical problems. When the standard and enhanced groups were compared improvements were greater in the enhanced group on 14 out of 21 measures and significantly so in respect of employment, drinking, crime, hospitalisation for medical problems, and % abstinent from opiates and cocaine though not in the average days of use of these substances or overall drug problems. Within four weeks the minimal care patients transferred to usual care showed substantial reductions in opiate and cocaine use, some reduction in drinking, and improvements in employment

A cost-effectiveness analysis of these outcomes found that the cost of services actually delivered (as opposed to available) per patient abstinent from heroin and cocaine was lowest for the intermediate option; further enhancements improved outcomes but were *not* cost-effective.[37] The main outcomes reported on were for the last month of the six-month period after the study had ended and all patients had returned to usual care though the cost-effectiveness results held also for outcomes at the end of the 24 weeks of the study. In both cases the minimal care condition cost substantially more per abstinent patient. All the patients who started in minimal care were included in that group even if they had prematurely been transferred to usual care. At the end of the follow-up period only the % abstinent from heroin use remained significantly different across the groups. The % abstinent from cocaine and heroin was 29% in the minimal care group but 47–49% in the other two groups, among whom the numbers abstinent had fallen since the end of the study, most substantially in the enhanced care group, from 68% to 49%. These outcomes do not reflect the impacts of the treatments at the time they were being delivered but their persisting impacts once they had ended. Costs included the follow-on usual care. This report says that the standard care group were offered

three counselling sessions a week (compared to one in the previous report) and then enhanced group seven (though the previous report says that the counselling requirements were the same as in the standard condition).

In the early '90s 353 patients admitted to a US methadone programme were randomly assigned to:[38]

– medication only: subjects in this level saw their counsellor once per month for 15 minutes to complete standard treatment contracts and receive referrals for whatever ancillary services they might need;

– standard: usual care consisting of four weekly individual counselling sessions for the first month of treatment which could then be tapered down to once a month after that. Counselling aimed to curb drug use by focusing on a variety of issues in the client's life which seemed to lead to drug use.

– enhanced: standard care plus an 8-week, twice per week, relapse prevention skill training group and weekly group therapy which might be anger management training, job seekers' workshops, women's and men's self-awareness groups and process groups. Patients could also participate in couples' counselling.

Cutting across these therapy regimes were two contingency conditions:

– none;

– or after 60 days a warning if three urine tests or breath alcohol were positive escalating to dose reductions for continued positive tests and then detoxification and discharge.

Across all conditions methadone doses (around 50mg on average) and staff were held more or less constant. Patients seemed typical of urban US programmes – unemployed single and criminally active. In-treatment urine analysis results over the first 18 months for illegal drug use (almost entirely heroin and cocaine) among patients retained for at least a month (all but 16 were) showed that nearly two-thirds of tests were positive. For opiates this was slightly but significantly more likely among patients not subject to contingencies who had been allocated to medication-only as opposed to standard care. Counter-intuitively, more severely problematic patients (in terms of employment, health, and pre-treatment cocaine injecting) recorded fewer opiate positives in the least intensive regimes and similar results were found for cocaine. This may have been because the enhanced services did not target their extra needs and may have seemed like an irrelevant diversion. All but a fifth of patients (the full sample including early drop-outs) were no longer in treatment after 18 months and this figure did not differ according to intensity of therapy.

That the quality of counselling in methadone programmes does matter was convincingly demonstrated in a further study from the VA-Penn group.[39] This retrospectively examined the differences in outcome for four drug counsellors who were appointed to a large number of clients in a virtually random fashion after the sudden resignation of two counsellors on the VA methadone maintenance program in Philadelphia. They found consistent differences across a range of outcomes between the counsellors. While two counsellors were moderately effective, the third was very effective and the fourth was not effective at all. The most effective

counsellor was able to bring his clients to a point over a six-month period where their drug use and unemployment were significantly reduced when compared with the six months prior to the change in counsellor, while at the same time reducing their use of both methadone and ancillary psychotropic prescriptions. By contrast, the clients of the least effective counsellor showed increased levels of unemployment, drug use and criminal activity, and needed more methadone and ancillary medication. When the differences between counsellors were examined, it was found that the most effective counsellor had postgraduate qualifications in psychology, while the least effective counsellor was an ex-addict with no tertiary education; the two moderately effective counsellors also had tertiary education. The three more effective counsellors kept well organised case notes, saw their patients frequently, were consistent in the application of program rules, and often referred their patients to other members of staff within the methadone maintenance unit and to outside agencies for specialist help. The least effective counsellor did not keep adequate case management notes, saw clients relatively infrequently, was inconsistent in responding to rule infractions, and seemed not to refer clients for specialist help. When the case notes were examined in detail for some indication of session content, it became clear that the most effective counsellor was able to help clients anticipate their problems and assist them in developing ways of dealing with them before they arose. This was the quality that most clearly distinguished this counsellor from the moderately effective ones who were similarly qualified. They went on to argue that the techniques reflected in the case notes were consistent with those features of psychotherapy that were found to be effective in comparison with DC in the psychotherapy project.

---

1 Yancovitz S.R. et al. "A randomized trial of an interim methadone maintenance clinic." American Journal of Public Health: 1991, 81, p. 1185–1191.

2 Friedmann P. et al. "Retention of patients who entered methadone maintenance via an interim methadone clinic." J Psychoactive Drugs: 1994, 26, p. 217–221.

3 Krook A.L. et al. "A placebo-controlled study of high dose buprenorphine in opiate dependents waiting for medication-assisted rehabilitation in Oslo, Norway." Addiction: 2002, 97, p. 533–542.

4 Dennis M.L. et al. "Effectiveness of streamlined admissions to methadone treatment: a simplified time-series analysis." Journal of Psychoactive Drugs: 1994, 26(2), p. 207–216.

5 Maddux J.F. et al. "Rapid admission and retention on methadone." American Journal of Drug and Alcohol Abuse: 1995, 21(4), p. 533–547.

6 Woody G. et al. "Rapid intake: a method for increasing retention rate of heroin addicts seeking methadone treatment." Comprehensive Psychiatry: 1975, 16(2), p. 165–169.

7 Strang J. Randomised clinical trial of the effects of time on a waiting list on clinical outcomes in opiate users awaiting out-patient treatment. National Treatment Agency for Substance Misuse, 2004.

8 Donmall M. et al. Waiting for drug treatment: effects on uptake and immediate outcome. Drug Misuse Research Unit, University of Manchester, 2002. Summary at www.mdx.ac.uk/www/drugsmisuse/execsummary.html.

9 Shanley J. et al. "Evaluation of a pilot low-threshold methadone programme." Journal of Substance Use: 2003, 8(4), p. 271–278.

10 Fernandez J. et al. "Low threshold: a future model for drug service provision? An evaluation of the model used in South Islington Drug Services." Journal of Research in Nursing: 2006, 11(1), p. 42–46.

11 Ramer B.S et al. "Is methadone enough? The use of ancillary treatment during methadone maintenance." American Journal of Psychiatry: 1971 127(8), p. 1040–1044.

12 McLellan A.T. et al. The effects of psychosocial services in substance abuse treatment. Journal of the American Medical Association: 1993, 269(15), 1953-1959.

13 Kraft M.K., Rothbard A.B., Hadley T.R., et al. "Are supplementary services provided during methadone maintenance really cost-effective?" American Journal of Psychiatry: 1997, 154, p. 1214–1219.

14 Saxon A.J. et al. "Pre-treatment characteristics, program philosophy and level of ancillary services as predictors of methadone maintenance treatment outcome." Addiction: 1996), 91(8), p. 1197-1209.

15 McLellan A.T. et al. "Is the counselor an 'active ingredient' in substance abuse rehabilitation? An examination of treatment success among four counselors." Journal of Nervous and Mental Disease: 1988, 176 (7), p. 423-430.

16 Brands B. et al. "Changing patient characteristics with increased methadone maintenance availability." Drug and Alcohol Dependence: 2002, 66, p. 11–20.

17 Brands B. et al. "Impact of methadone program philosophy changes on early treatment outcomes." Journal of Addictive Diseases: 2003, 22(3), p. 19–38.

18 National Treatment Agency for Substance Misuse. Waiting times. Guidance notes to adult drug treatment plans 2006/07. 3 October 2005.

19 Fernandez J. et al. "Low threshold: a future model for drug service provision? An evaluation of the model used in South Islington Drug Services." Journal of Research in Nursing: 2006, 11(1), p. 42–46.

20 Strang J. Randomised clinical trial of the effects of time on a waiting list on clinical outcomes in opiate users awaiting out-patient treatment. National Treatment Agency for Substance Misuse, 2004.

21 Best D. et al. "The relative impact of waiting time and treatment entry on drug and alcohol use." Addiction Biology: 2002, 7, p. 67–74.

22 Donmall M. et al. Waiting for drug treatment: effects on uptake and immediate outcome. Drug Misuse Research Unit, University of Manchester, 2002. Summary at www.mdx.ac.uk/www/drugsmisuse/execsummary.html.

23 Shanley J. et al. "Evaluation of a pilot low-threshold methadone programme." Journal of Substance Use: 2003, 8(4), p. 271–278.

24 Jones M., Jones S., Connolly M. "Asking around: the theory and practice of user consultation." Druglink: March/April 1998, p. 14–17. 504 drug service users were asked to list the services most helpful in meeting their needs. Of those who mentioned counselling as a need to be met (108 from 420 – the largest single category of needs) 18 mentioned DDUs as among the top five services meeting these needs compared to 56 mentioning street agencies. Among those who had stayed drug free for at least a month, the highest proportion (26%) mentioned counselling/support as what helped them do it compared to 16% methadone.

25 Glasscote R. et al. The treatment of drug abuse: programs, problems, prospects. Washington, DC: Joint Information Service, 1972. See p. 127–151.

26 Ramer B.S et al. "Is methadone enough? The use of ancillary treatment during methadone maintenance." American Journal of Psychiatry: 1971 127(8), p. 1040–1044.

27 Yancovitz S.R. et al. "A randomized trial of an interim methadone maintenance clinic." American Journal of Public Health: 1991, 81, p. 1185–1191.

28 Friedmann P. et al. "Retention of patients who entered methadone maintenance via an interim methadone clinic." J Psychoactive Drugs: 1994, 26, p. 217–221.

29 Krook A.L. et al. "A placebo-controlled study of high dose buprenorphine in opiate dependents waiting for medication-assisted rehabilitation in Oslo, Norway." Addiction: 2002, 97, p. 533–542.

30 Dennis M.L. et al. "Effectiveness of streamlined admissions to methadone treatment: a simplified time-series analysis." Journal of Psychoactive Drugs: 1994, 26(2), p. 207–216.

31 Maddux J.F. et al. "Rapid admission and retention on methadone." American Journal of Drug and Alcohol Abuse: 1995, 21(4), p. 533–547.

32 Woody G. et al. "Rapid intake: a method for increasing retention rate of heroin addicts seeking methadone treatment." Comprehensive Psychiatry: 1975, 16(2), p. 165–169.

33 This not explicitly stated but the authors attribute the result to patients having effectively to decide

twice whether to seek treatment since they did not see the initial contact as actually entering treatment.

34 Brands B. et al. "Changing patient characteristics with increased methadone maintenance availability." Drug and Alcohol Dependence: 2002, 66, p. 11–20.

35 Brands B. et al. "Impact of methadone program philosophy changes on early treatment outcomes." Journal of Addictive Diseases: 2003, 22(3), p. 19–38.

36 McLellan A.T. et al. The effects of psychosocial services in substance abuse treatment. Journal of the American Medical Association: 1993, 269(15), 1953-1959.

37 Kraft M.K., Rothbard A.B., Hadley T.R., et al. "Are supplementary services provided during methadone maintenance really cost-effective?" American Journal of Psychiatry: 1997, 154, p. 1214–1219.

38 Saxon A.J. et al. "Pre-treatment characteristics, program philosophy and level of ancillary services as predictors of methadone maintenance treatment outcome." Addiction: 1996), 91(8), p. 1197-1209.

39 McLellan A.T. et al. "Is the counselor an 'active ingredient' in substance abuse rehabilitation? An examination of treatment success among four counselors." Journal of Nervous and Mental Disease: 1988, 176 (7), p. 423-430.