1.4 (Some) counselling maximises methadone's cost-effectiveness

Findings For the first 24 weeks 100 US clients starting methadone maintenance were randomly assigned either to *minimum* support (monthly counselling session), *intermediate* (three sessions a week), or *enhanced* support (seven sessions a week plus medical, psychiatric, employment and family therapy services). More support led to better outcomes in terms of drug problems, crime and health. However, for each patient abstinent from heroin and cocaine, the cost of services actually delivered (as opposed to available) was lowest for the intermediate option; the further enhancements improved outcomes but were *not* cost-effective.

Over the next six months all subjects reverted to the intermediate level of support and their behaviour converged. By the end, only the heroin abstinence measure remained significantly poorer in the minimal support group. In the enhanced group a 68% abstinence rate at 24 weeks dropped to 49%. Cost effectiveness remained highest in the intermediate group.

In context Several studies have shown that increasing access to counselling or social services can improve methadone outcomes. Such findings are not universal, perhaps partly because much depends on the *quality* of the services and on access to housing, employment, and training opportunities beyond the programme's control. However, service enhancements absorb resources which could otherwise be used to expand basic treatment slots; is it best to spread thin but wide and treat more clients, or do more work with fewer? This study suggests that increasing availability of counselling modestly (to three times a week, uptake in practice under once a week) buys more abstinence per dollar than offering daily access plus other services. There is some evidence that UK drug service clients value counselling and feel it is effective but generally do not find prescribing services meet their needs in this regard.

Practice implications The ceiling beyond which services supplementing methadone are no longer cost-effective may be quite low for many people though higher for those with greater problems. To gain worthwhile further benefits, services may need to forge links with external agencies such as those dealing with training/education, housing and employment. There is also a floor below which cost-effectiveness suffers through inadequate support. Cost-effectiveness is probably maximised by making more intensive, well managed counselling and other services *available* for those who feel they need them, or where referral to such services seems advisable. UK prescribing services could meet these needs more systematically.

Main sources 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. Copies: apply ISDD.

Secondary sources Mattick R., Ward J., Hall W. "The role of counselling and psychological therapy." In: Ward J., Mattick R., Hall W., *eds*. *Methadone maintenance treatment and other opioid replacement therapies*. Harwood Academic, 1998, p. 265–304.