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▶ Methadone patients in the therapeutic community: a test of equivalency.

Sorensen J.L., Andrews S, Delucchi K.L. et al. Request reprint

Drug and Alcohol Dependence: 2009, 100, p. 100–106.

Are therapeutic communities incompatible with methadone maintenance? Not when staff have been prepared to accept and work with methadone patients and programmes adapted to accommodate them. Then patients stay as long and sustain abstinence from illegal drug use just as well as other residents.

Abstract Residential therapeutic communities have demonstrated effectiveness, yet for the most part they adhere to a drug-free ideology incompatible with the use of methadone. This study used equivalency testing to explore the consequences of admitting opioid-dependent clients currently on methadone maintenance treatment into a therapeutic community. The study compared 24-month outcomes between 125 methadone patients and 106 opioid-dependent drug-free clients with similar psychiatric histories, criminal justice pressures and expected lengths of stay, who were all newly enrolled in a therapeutic community. Statistical equivalence was expected between groups on retention in the therapeutic community and illicit opioid use. Secondary hypotheses posited statistical equivalence in the use of stimulants, benzodiazepines, and alcohol, as well as in HIV risk behaviours. As hypothesised, the average number of days in treatment was statistically equivalent for the two groups (166.5 for the methadone group and 180.2 for the comparison group). At each assessment, the proportion of the methadone group testing positive for illicit opioids was indistinguishable from the proportion in the comparison group. The equivalence found for illicit opioid use was also found for stimulant and alcohol use. The groups were statistically equivalent for benzodiazepine use at all assessments except at 24 months where 7% of the methadone group and none in the comparison group tested positive. Injection- and sex-risk behaviours were equivalent at all observation points. The authors concluded that in these therapeutic community settings, methadone patients fared as well as other opioid users, providing additional evidence that therapeutic communities can successfully be modified to accommodate methadone patients.

FINDINGS Generally considered incompatible treatment modalities, this is one of the

few studies to show that a therapeutic community environment can be combined with methadone maintenance, and the first to do so in respect of a residential community. As the authors stress, it is important to remember that these were not the usual run of communities. For decades they had embraced methadone patients and made modifications to meet their particular needs and increase their acceptance by staff and residents. It's also possible that these modifications and the presence of methadone patients changed the environment for non-methadone residents too. Residents were not randomly allocated to the two regimens but entered the facilities in the normal way. All had the kind of experience of opiate use which would have made them eligible for methadone maintenance, they were matched on some key variables and differed little on most others, yet before, during and after leaving the communities, far more of the methadone group were in methadone treatment. The implication is that the major remaining difference between the two groups of residents lay in their preferences for alternative routes to recovery – complete abstinence, or abstinence from illegal drugs supported by substitute prescribing. The outcomes seem to suggest that in welcoming and suitably modified communities, residents who favour these different routes end up abstinent from illegal drugs in roughly the same numbers and converge somewhat in their preferences for how to attempt to maintain this. They also show that many from both camps do not totally succeed. What we don't know, however, is how the residents fared in other ways such as reintegration and mental and physical well being.

Though this study seems unique, previous reports have documented the integration of non-residential day care therapeutic communities with methadone programmes, demonstrating that patients who opt for this additional support evidence greater remission in opiate and cocaine use. Other studies have established that with staff facilitation, 12-step mutual aid groups can (but not always smoothly) be integrated with methadone treatment and that patients who choose this option seem to benefit. Such initiatives are line with the cooperation between the founders of Alcoholics Anonymous and Vincent Dole, founder of methadone maintenance, who served on AA's board.

Simultaneous integration of residential rehabilitation and methadone is by no means unknown in Britain, but far more common is the serial integration of these modalities within a client's treatment journey. In Scotland's DORIS study of drug treatment services, within 33 months most clients starting residential rehabilitation had left and spent a period on methadone. In England's similar NTORS study, perhaps a third had done so within a year. In neither case do we know how many rehabilitation clients had traversed the opposite route, though its seems likely that many had.

Thanks for their comments on this entry in draft to James L. Sorensen of the UCSF at San Francisco General Hospital. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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