An Evaluation of Private Methadone Clinics

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An Evaluation of Private Methadone Clinics James Bell, Jeff Ward, Richard Mallick, Anna Hay, Jennifer Chan, Wayne Hall.

The Study:

"Private" methadone clinics in which patients pay dispensing fees, and medical practitioners are remunerated on a fee-for-service basis by Medicare, now treat the majority of patients receiving methadone treatment in N.S.W. (New South Wales).

The aim of this study was to provide a comprehensive description of the patients, the nature of treatment delivered in these clinics, and their effectiveness in reducing drug use and drug dependence.

Three private methadone clinics were studied. Three hundred and four patients were recruited, and were interviewed three times over twelve months. A parallel study, using the same core data collection instruments, studied 358 patients in public methadone clinics, to provide comparisons between the two sectors.

Psychiatric status of private clinic patients was investigated using a structured interview, the Composite International Diagnostic Interview.

Treatment delivered:

Public and private clinics differed in that private clinics charged dispensing fees, had frequent, usually brief medical consultations, no other formal counseling, had lower staff-patient ratios, and provided many more take-away doses of methadone.

Urine testing as used in all these clinics did not provide an accurate record of drug use. The process of testing was disliked by staff and patients. By using urine test results as a way of determining which patients need higher methadone doses, some prescribers were systematically under dosing patients.

In all private clinics the availability of take-away doses of medication appeared a matter of policy rather than being based on patients' stability in treatment. Selling and injecting of take-away doses was not rare.

In all private clinics there were no written policies and procedures, and no written job descriptions. Stated policies were frequently not enforced. There was a lack of staff training and supervision. Particularly in one clinic, the lack of training, poor team cohesion and ineffective communication led to chaotic clinic functioning.

Based on current (last six months) symptoms, 21% met the criteria for major depression, 26% social phobia, and 8% panic disorder. Thirty six percent met the criteria for antisocial personality disorder based on current symptoms. These figures indicate a very high prevalence of significant psychiatric disability.

Unemployed subjects were nearly six times more likely than employed subjects to leave treatment in private clinics. Reliance on private clinics to provide methadone treatment reduces access to treatment for unemployed people.

Despite reporting high levels of satisfaction with medical treatment received in the private clinics, over 60% of subjects had seen a doctor outside the methadone clinic in the month before interview. This high rate of medical care seeking reflected both high levels of benzodiazepine use, and a preoccupation with somatic symptoms. Patients of one clinic, which featured less frequent, but long prescriber consultations, had significantly less visits to other doctors.

Heroin use:

On entry to treatment in all clinics, there was a prompt and substantial drop in heroin use. This was associated with parallel reductions in social dysfunction, crime, and HIV risk taking. About half the subjects continued to use heroin for a period of time in treatment, usually using infrequently. This infrequent heroin use was associated with low levels of psychological dependence and with low levels of needle sharing.

There were large differences in the level of continuing heroin use between clinics. Patients of the least effective clinic were much more likely to have used heroin in the month prior to interview than those at the most effective clinic (Odds Ratio 2.4, 95% confidence intervals [1.2, 4.8]).

Higher doses of methadone were associated with less heroin use and lower psychological dependence on heroin. Treatment factors other than dose were also important in influencing the rate of heroin use.

In two private clinics, there was a progressive reduction in the number of subjects using heroin with increasing duration of treatment. This discontinuation of heroin use occurs in those subjects using heroin less frequently, and in those whose psychological well-being had improved. In the third clinic there was no reduction in heroin use with increasing duration of treatment.

Although treatment factors were important predictors of outcome, subject characteristics such as employment, education, diagnosis of antisocial personality disorder, were not predictive of heroin use or HIV risk taking.

Other treatment outcomes:

Non-opioid drug use was very common among patients in these methadone clinics. About 1/3 of subjects had used benzodiazepines, abut cannabis, and about 1/6 amphetamines in the month prior to interview 1. Only 70 subjects (23%) reported having used none of these 3 classes of drugs in the month prior to interview. Of these 70 subjects, 40 had used heroin in the month prior to interview. Thus, only 30 subjects (10% of the sample) reported no use of psychoactive drugs other than methadone.

Such drug use often involved levels of consumption which were associated with risks of dependence and other harm. Altogether, 131 subjects (43%) were using at least one of these non- opioid drugs in hazardous quantities. Only 79 subjects (26%) reported no use of heroin, and no harmful use of the four classes of non-opioid drugs.

In treatment, use of non-opioid drugs was usually a continuation of pre-treatment patterns of use. There was no dramatic change on entering treatment. About 1/3 of cannabis smokers increased their level of consumption during treatment. Persisting cannabis use was associated with greater social dysfunction and involvement in crime.

With increasing duration of treatment, there was a drop in amphetamine use but little change in cannabis, benzodiazepine and alcohol use. There was evidence that higher methadone doses did not suppress non-opioid drug use.

There was a marked reduction in involvement in crime among patients during methadone treatment, attributable to reductions in heroin use. Cannabis use was the major predictor of continued involvement in crime during methadone maintenance.

After the initial benefits associated with entry to treatment, most further benefits of treatment appear to be contingent on improvements in psychological symptoms. There was little evidence that treatment as delivered in these clinics produces beneficial changes in psychological distress. The level of care provided in private methadone clinics appeared adequate for a majority of patients. However, a significant minority - particularly patients expressing high levels of psychological distress - appeared to need more intervention.

Differences in treatment effectiveness:

One private clinic stood out in having the lowest rate of heroin use, and least attrition from treatment. In this clinic, the prescriber systematically raised almost all patients to a dose of 80 mg/day.

Another private clinic stood out as performing worst on all treatment outcomes. The aspects distinguishing this clinic were poor management, the lowest staff-patient ration, poor communication among staff and between staff and patients, and poor clinical records. This clinic was rated lowest by patients.

Differences in outcomes between clinics within the public and private sectors were greater than differences between the sectors.

Aspects of staff-patient interaction are important determinants of outcome, but the availability of counseling, at least as delivered in the public clinics, was not one of those aspects. Rather, organizational and logistic factors within the clinics appeared to be the major factors which contributed to differential treatment effectiveness.

Source: Prevention Resource Centers, Annandale, New South Wales, Australia. Louise Perkins, Lambton Families In Action for Drug Education Inc., Sarnia, Ontario, Canada.

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