▶ An evaluation of private methadone clinics.

Bell J., Ward J., Mattick R.P.. et al.

[Australian] National Drug Strategy Research Report no. 4. Australian Government, 1995.

Comparison of three Australian clinics highlights the importance of good organisation and a treatment ethos entailing an individualised approach, rather than the clinic acting mainly as a 'methadone dispenary'.

This account of the featured study is extracted and slightly edited from the account by the first author of the study, James Bell, in the chapter, "Delivering effective methadone treatment", in the book, *Methadone maintenance treatment and other opioid replacement therapies*, published by Harwood Academic Publishers in 1998.

A recent study of methadone clinics in Sydney provided some useful insights into how treatment effectiveness might be improved. In the Sydney study, one clinic was strikingly less effective than the others. This provided some valuable insights into factors that detracted from the effectiveness of treatment.

Main findings

The first clinic was highly organised, and could best be characterised as businesslike (right down to the fact that the administrator regularly undertook time and motion studies to ensure that dispensing of methadone was being carried out efficiently). Patients in this clinic received higher doses of methadone (average daily dose 76mg), and this clinic had least heroin use, a result probably attributable to the higher doses of methadone being prescribed. The clinic functioned as a highly efficient methadone dispensary, with little attention to 'treatment'. Clinical records were poorly kept.

The second clinic was less highly organised, but more individualised. Instead of a businesslike approach, the ethos in this clinic was 'medical', with well-maintained clinical records, and attention paid to individual problems. Lower doses of methadone were prescribed (average 53mg). Heroin use in this clinic was higher than in the first clinic, but fell progressively over the 12 months of the study. Non-opioid drug use and crime were lowest among patients attending this clinic, and it was rated highest of the three clinics by the patients themselves.

In the third clinic, the atmosphere was chaotic. Staff worked in an atmosphere of perpetual crisis, but made little or no attempt to alter this reactive mode of operating. On one occasion when researchers were in the clinic, an arbitrary and abrupt change in policy regarding take-home medication led to a wave of anxiety and resentment among the patients. There was a pervasive sense of disorganisation and frustration within the clinic. Clinical records were very poorly maintained. Methadone doses were moderate (average 55mg), but the outcomes of treatment were poor. Adjusting for subject variables, this clinic had significantly worse outcomes in terms of retention in treatment, heroin use, non-opioid drug use, and crime. Perhaps most tellingly, patients asked to rate their treatment also rated this clinic lowest of the three.

Despite the different ethos in the three clinics, in many key respects treatment delivered was remarkably similar. The clinics had similar admission policies. Patients were almost never involuntarily withdrawn from treatment in any of the clinics. The clientele in the three clinics was similar. Levels of services, staff training, and treatment philosophy were similar. However, where the clinics differed was in the 'style' of treatment, and these differences in style were associated with significant differences in outcomes.

Equally striking as the differences between the clinics was the observation that in all three of them, for most staff and patients, methadone maintenance treatment was something of a ritual, with little clear rationale for what was occurring. The absence of a frame of reference for approaching methadone treatment was apparent, not just in the differences between the clinics, but in the interaction between staff and patients within each clinic.

The authors' conclusions

These observations lead to three suggestions as to how treatment could be improved.

Treatment ethos

Many clinicians and researchers see methadone maintenance treatment as a 'programme', a preventive or public health measure rather than a treatment of individuals. While this perspective undoubtedly has validity, it can contribute to significant problems in the delivery of effective care. 'Treatment' brings with it assumptions of attention to individuals and good clinical practice, assumptions more rigorous than any regulations stipulating minimum standards of care. These assumptions include the necessity for good clinical records. More importantly, a 'treatment' ethos provides a framework in which all interactions with patients are understood as part of the care of the individual. Thus issues of anger, conflict and acting out become part of the material being worked with, rather than an irritation or obstacle to the smooth running of the clinic.

In large methadone clinics, it is probably more difficult to maintain an ethos of individualised treatment. This is a strong argument for locating methadone treatment in primary care settings. This has obvious advantages in making treatment more anonymous, less stigmatised, and more accessible. It avoids the problems of loitering associated with large methadone clinics. It also locates methadone maintenance in a setting where the 'treatment' framework is assumed, and where the governing assumption is the care of individuals rather than providing a social service.

Dose setting

Research has been reasonably consistent in demonstrating that an adequate dose of methadone is an important determinant of treatment efficacy . Many patients are ambivalent about being on methadone, and fear that higher doses will have adverse effects. However, in the studies of methadone clinics in North America and in Sydney, it is apparent that clinic policies influence dose levels. Thus, sub-optimal doses cannot be primarily attributed to patients' reluctance to be placed on higher doses. It is the clinician's responsibility to address ambivalence and encourage patients to take adequate doses.

Organisation

Working with heroin users is stressful for a variety of reasons, not the least being negative community attitudes towards treatment. Staff are at risk of burnout, disillusionment and cynicism. Such consequences are an unacceptable cost for health professionals, and are probably also potent factors reducing the effectiveness of treatment. Structured and well-organised treatment, with clear

rationale and objectives, is one way of minimising these problems.

Staff should have job descriptions, with clear delineation of roles and responsibilities. Lines of communication need to be clear and observed. (This applies as much in a clinic as in a primary care setting between physician and dispensing pharmacist.) Regular team meetings to discuss problems and review policies allow staff to clarify their responses to the pressures of working in methadone treatment.

A structured approach to treatment is helpful, as long as the structure does not constitute a barrier to entering treatment or is an intrusive burden on patients. For example, intake into treatment should be prompt, based on an interview focused on establishing the patient's suitability for treatment, rather than following exhaustive assessment. At the initial visit, treatment policies, and what staff expect of patients should be clarified. Such issues as frequency of attendance for review or counselling sessions, dosing times and rules regarding payment, need to be clearly spelt out. During subsequent weeks of treatment a more detailed assessment, and formulation of a treatment plan can be undertaken. Clinical records should clearly document the important issues in each individual's treatment.

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