Interim methadone treatment compared to standard methadone treatment: 4-month findings.

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Is regular counselling really essential to the effectiveness of methadone maintenance treatment, or are treatment entry and the power of high-dose methadone enough in themselves for many patients? At least in the first four months, this US study suggests the latter.

Summary These are the outcomes in the featured study four months after patients started treatment. See this later analysis for 12-month outcomes.

This US study addresses the issue of whether regular counselling improves initial outcomes from methadone maintenance treatment. The context is that federal regulations require regular counselling except under special authorisation and then counselling can be omitted only for up to 120 days – hence the term "interim" for this stripped-down provision. By forcing counselling provision, the regulations limit the number of methadone slots which can be provided under current funding and inhibit access for patients who have to pay all or some programme costs. Previous studies had shown that compared to the alternative of waiting for a standard methadone treatment slot, interim provision substantially reduced opiate use and crime and led many more patients to eventually start regular methadone treatment. But these studies left open the issue of whether offering rapid access to standard programmes would be even more effective than offering rapid access to interim programmes.

To investigate this issue, at two methadone clinics in Baltimore, new patients were randomly assigned to start (usually within three days) an interim programme or standard treatment. As per regulations, the interim programme could last only up to 120 days, offered crisis counselling only, required patients to take all their methadone under supervision at the clinics, and at least three tests for illegal drug use. In the standard regimen, patients were expected to attend weekly group and/or individual counselling sessions (with some room for adjustment to patient needs), permitted take-home doses depending on time in treatment and progress, were subject to more frequent drug testing than in the interim programme, and were able to benefit from care planning and other psychosocial inputs. At one of the clinics patients were also randomly assigned to a third option – the standard programme plus enriched counselling provision by a highly regarded counsellor with a low caseload who was instructed to see patients as often as they wanted or the counsellor thought appropriate. Dosing protocols did not differ, and patients ended up on doses averaging from 68mg to 79mg a day across the three groups, the highest average being among the interim patients.

Main findings

The 230 patients recruited to the study and successfully assigned to one of the three treatment regimens were typically unemployed single black men in their early 40s who used heroin daily. All but a few were followed up by researchers four months later when the interim programme had to have stopped or been replaced by standard provision (on average the patients were in the interim stage nearly all the 120 days). As expected, during this time the interim patients received virtually no counselling sessions, the standard patients about one a fortnight, and the enhanced patients about one per week.

The first important finding was that interim patients were no less likely to have stayed in treatment; 92% did so compared to 81% of standard and 89% of enhanced patients. Over this time heroin use declined substantially and cocaine use more modestly, both to roughly the same degree in all three treatments. Heroin use fell from on average virtually daily to two to four days a month according the patients' own accounts, broadly confirmed by urine tests which were 97% positive at first but fell to 41% to 51% positive. Self-reported drug, legal and family problems all declined too, and to roughly the same degree across the three treatments. Crime indicators actually fell slightly more steeply among interim than standard programme patients. These results generally indicative of no differences in outcomes across treatments were broadly replicated in a comparison of the interim patients with all remaining study participants assigned to more frequent counselling.

The authors' conclusions

While across the board there was significant improvement, being assigned to scheduled counselling versus the interim regimen did not further improve retention, illicit drug use and related problems, or criminal activity. The study found no evidence that interim patients were substantially disadvantaged by the four-month period during which only emergency counselling was available.

However, even the most frequently counselled group in the study were seen on average once a week. More intensive or different forms of counselling and other forms of support might have made more of a difference. Conceivably too, the benefits of extra counselling would be seen in more sustained improvement following the four-month break point imposed by regulations.

The findings are consistent with other studies conducted at typical US community-based methadone clinics. They strongly suggest that the regulation of opioid agonist treatment should allow for provision of additional services where these are both helpful to patients and wanted by them rather than making such services obligatory. As well as increasing costs by imposing services that may or may not be needed, mandating these services has the unintended consequence of denying access to more basic treatment which is demonstrably valuable to patients and the society in which they live.

FINDINGS Together with this latest study, similar studies (including some in the UK) reviewed in detail by Findings have shown that 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.

It is, however, important to remember that this (and the same applies to other studies of interim arrangements) was far from a 'contactless' programme. Every day of the week over the entire period, interim patients had to attend the clinic to take their methadone under supervision – more staff contact than many British patients experience. 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. However, it would be widely considered unacceptable to leave patients on minimal programmes without regular review probing for and seizing opportunities to make yet further improvements in their welfare and recovery from addiction, including ways to solidify their recovery sufficiently for them to safely leave methadone treatment. In turn this

raises what in Britain is a key current issue of whether more intensive counselling, even if it seems to add little to the powerful effect of *entering* methadone treatment, might help people get sufficiently on their feet to more to *leave* this treatment and leave it earlier.

One caveat to the findings mentioned by the authors is worth emphasising – that the difference counselling makes will depend on the quality and nature of that counselling and also on the quality and nature of the counsellor. Perfunctory brief encounters focused on dose, prescribing and dispensing arrangements, attendance records, and regulatory and disciplinary issues are unlikely to engender step change in the client's recovery, yet are characteristic of the keyworking service offered by some British criminal justice teams to offenders on opiate substitute prescribing programmes.

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