More than just methadone dose: enhancing outcomes of methadone maintenance treatment with counselling and other psychosocial and ‘ancillary’ services

Methadone series

There is now substantial evidence on the effectiveness of methadone maintenance treatment. Research has also identified the factors likely to be necessary to achieve optimal methadone treatment. Three briefings for drug treatment providers and commissioners have been produced on these factors:

- Methadone dose and methadone maintenance treatment
- Enhancing outcomes of methadone maintenance treatment with counselling and other psychosocial interventions and provision of ‘ancillary’ services
- Engaging and retaining clients in drug treatment

Most opioid users seeking treatment present to services with a range of problems including severe family and social problems, employment difficulties and use of other illicit drugs. Many have co-morbid psychiatric disorders or other co-morbidity (e.g. HIV or hepatitis C infection). These problems may impede the progress of service users and work against their retention in treatment. Retention is acknowledged as having a major association with good outcomes.

It has been found that the more successful methadone treatments are those that reflect a good organisational management, through providing a range of services that maximise the effectiveness of methadone and can improve client outcomes. These include counselling and other psychosocial interventions and provision of ‘ancillary’ services. This briefing focuses on the evidence demonstrating the importance of this range of provision.

Research into practice briefings are also available online at www.nta.nhs.uk
Key findings

- Some counselling can improve the treatment outcomes of most users of methadone maintenance treatment.
- The amount and type of psychosocial input required depends on individual need.
- Psychotherapies and, in particular, cognitive-behavioural therapies (CBT), have a positive evidence base for those with more specific needs. CBT has produced good outcomes with crack/cocaine users who are on methadone maintenance treatment.
- Involving significant others in treatment is feasible and can lead to improved outcomes.
- Counsellor/keyworker skills and attributes can have as big an impact on outcomes as the intervention itself.

Research into practice briefings

These briefings commissioned by the NTA are summaries of the research evidence on a particular topic to help inform providers and commissioners of services. They are not NTA guidance but are aimed at helping providers and commissioners reflect on local service provision. It is important to note that UK-based research on the issues covered by this series of briefings is currently limited and many of the studies reported here have been conducted in the USA. How such research evidence, relating to methadone maintenance treatment, is appropriately applied to clinical practice in the case of individual service users is a decision for treatment services' team members. This should be applied in discussion with the service user taking all the relevant issues into account. Clinical teams should work within clinical governance including clear protocols and regular clinical audit to ensure good practice.

Introduction

This briefing focuses on the evidence for the role of counselling and other psychosocial interventions and provision of 'ancillary' services in methadone maintenance treatment. There is now substantial evidence for the effectiveness of methadone maintenance. This is particularly the case where there is provision of adequately high doses (with average doses of 60mg to 120mg being particularly identified as demonstrating benefits). Other important factors suggested by research include flexible, individualised dosing regimes and responsive treatment services. In addition, approaches that engage and retain service users in treatment enhance positive treatment outcomes. These issues are addressed in the other briefings in this series.

There is substantial evidence of the effectiveness of methadone maintenance in terms of improvements in health and social functioning and reduction in crime and drug-related deaths. Other briefings have looked at the importance of adequate dosing and good client/therapist relations as key to achieving good treatment outcomes. This briefing focuses on counselling and other psychosocial interventions and the provision of ‘ancillary’ services as part of methadone maintenance treatment. Issues relating to these interventions with crack cocaine and other stimulant users have been addressed by another NTA briefing. Nonetheless, some of the studies mentioned here have also included crack users and many of the research findings are equally applicable to practice development in opiate as well as crack cocaine treatment. Similarly, the research findings reported here are generally applicable to buprenorphine maintenance, which is an increasingly used form of prescribing. In UK practice, the term ‘counselling’ may often refer inappropriately to informal key working rather than structured counselling approaches.
with clearly defined treatment goals, which is the definition adopted by Models of care and this briefing. Methadone alone has some benefit, but a care-planned approach to maintenance treatment, which provides psychosocial interventions as well as prescribing, achieves better client outcomes. Methadone maintenance providers with a greater range and quantity of services have been shown to be associated with improved retention and client outcomes⁶⁻⁷⁻⁸.

Counselling services, and how they are delivered, can have as critical a role to play in service user outcomes as methadone dosage⁹. The Drug Abuse Treatment Outcome Study (DATOS) found a range of retention rates within methadone programmes in the US, with the majority of service users leaving within 12 months at one end of the scale, while at the other end, programmes were able to retain three quarters of their clients for at least this period. Evidence suggests that client-receptive services have the greatest success in getting service users to stay. Services that quickly establish a therapeutic relationship with their clients, giving helpful and positive responses to the range of clients’ problems, are more likely to encourage engagement with treatment.

What little evidence we have on the preferences of people in methadone treatment in the UK suggests that they see counselling as part of a responsive service⁶. However, counselling services are not an integral part of methadone maintenance treatment in Britain. Just one quarter of the methadone treatment services in the National Treatment Outcome Research Study (NTORS) reported the availability of weekly individual counselling services and only one reported weekly group counselling sessions for most or all of their clients⁷.

Similarly, the Audit Commission recently found that many services were not providing adequate care management for clients and that less than 50 per cent had care plans. Services were also not considering the wider needs of clients, nor actively organising help from other relevant services⁶.

2. The impact of psychosocial and ‘ancillary’ services

A number of US studies have demonstrated that providing counselling, medical and psychosocial services in addition to methadone maintenance can have a direct impact on outcomes. Most notably a trial by a research group in Philadelphia randomised patients to one of three approaches: no counselling; minimal counselling; or enhanced services which included regular medical and psychiatric care, social work assistance, family therapy and employment help on site. While those in the minimum service group did show a reduction in their drug use, the addition of basic counselling was associated with better outcomes and the provision of on-site enhanced services led to even better outcomes⁹. Sixty nine per cent of the patients in the no counselling group had to be transferred to the minimal counselling group after evidence of continued heroin use.

To test these results in a “real-world” setting, the same research group compared standard methadone services with enhanced services in outpatient programmes and found that those in the enhanced programmes had significantly better outcomes at six month follow-ups. Importantly, the study found that putting the enhanced services in place took time and any early evaluation would have missed the full impact of the changes to services⁹.

Drug treatment services may need to make links pro-actively with external agencies providing training, education, housing and employment, so that clients who need them can gain the benefits of enhanced approaches. External agencies must be accessible. Another US study found that, while enhanced services did lead to better retention, the clients had difficulty taking advantage of the services offered. Clients were unwilling to approach support services and these services were unwilling to work with the methadone clients⁹.
3. What level of service is most effective?

Studies have demonstrated that methadone maintenance treatment programmes providing a high level of input to clients, including adequate and regular counselling and other psychosocial interventions, can improve outcomes. What is more difficult to determine is what level of service promotes better outcomes.

Evidence suggests that there is a ceiling at which counselling sessions can become counter-productive and very frequent counselling sessions have been associated with poor retention. American researchers compared the outcomes of service users receiving enhanced treatment with manual-driven counselling sessions, with the outcomes of those on high intensity day treatment involving skills training and access to off-site services. Both groups showed similar results, with a decrease in illicit drug use, HIV risk behaviours and drug-related problems. However, those new to treatment were more likely to be retained and to be abstinent if they received the lower intensity treatment. This suggests that there may be a maximum level of attendance that will be acceptable to some clients.

Another US study compared patients switched from an intensive regime to a more relaxed approach. Not only was stability maintained, but also the service users preferred this approach. The study’s authors suggested that the time spent getting to the clinic two or three times a week and waiting for methadone or counselling impeded these patients from their employment prospects or being with their families.

4. What is cost-effective?

Further analysis of the data from the Philadelphia studies explored the total treatment costs against reductions in welfare and criminal justice costs. It found that the standard level of counselling was the most cost beneficial. These results suggest that, for most clients in methadone treatment, making counselling available three times a week (although in practice only one of these sessions is likely to be taken up) is more cost-effective than daily contact.

5. Beyond standard counselling: cognitive-behavioural therapies and other psychotherapies

Cognitive-behavioural therapy (CBT) has shown promise in providing additional benefits in methadone treatment. One study of cocaine-using methadone patients compared treatment, which included CBT and relapse prevention, with a discussion group. It found reduced illicit drug use and an improvement in psychosocial functioning with the CBT approach.

Another US study on efficiency and cost compared enhanced methadone maintenance, including group counselling skills, with high intensity daily treatment. It showed similar outcomes in terms of illicit opiate or cocaine use but with the daily treatment costing significantly more.

Intensive psychotherapy may produce better outcomes for particular groups of people. For example, a study found that service users with more severe problems showed significant improvements in a high intensity intervention compared to a low intensity psychosocial intervention. Those who completed the programme sustained these improvements at follow up. Another study that focused on service users with social anxiety found that those in low intensity general treatment who were offered anxiety management skills did better than those in the general treatment group.

There have been few controlled trials looking at other psychotherapies. One US study found that supportive expressive therapy helped patients to maintain lower methadone doses and treatment gains after six months compared to general counselling and support. A number of studies have shown the
value of a diagram technique called node link mapping, with diagrams of the service users’ problems linked to solutions to these problems. This has been found particularly helpful with those clients who may find it difficult to discuss their problems and solutions with professional therapists. It was also found to improve communication, leading to improved engagement and outcomes20. An NTA briefing focusing on the effectiveness of psychological therapies in the treatment of substance misuse will be published shortly.

6. Involving significant others and other networks

There is some evidence of the benefits of involving significant others in treatment. An early controlled study of psychotherapy in methadone patients involved structured family therapy, with four treatment types being compared: paid family therapy; unpaid family therapy; paid family film-watching plus counselling; and counselling. The results provided some evidence for better outcomes for family therapy. However, the intervention proved unattractive to the busy therapists who found the families difficult to engage21.

A more recent study has demonstrated that service users can be motivated to include significant others in their treatment by behavioural interventions around methadone dosing22. Community reinforcement approaches have also been found to be effective when added to standard methadone treatment. These involve using elements such as leisure, skills training, employment assistance and recruiting important people in the client’s social and family life to encourage progress23.

7. Training and employment

Studies have shown that the aspirations of the users of methadone treatment services to participate in the workforce are similar to those of the wider society. For example one US study found that three quarters of the methadone clients in the study wanted further training and education for a professional or technical position24. Services that attempted to meet these needs by introducing case management achieved improved patient outcomes. Service users who had been through these enhanced programmes were less likely to have needed further addiction treatment within six months of leaving25.

8. The key worker matters

A number of studies have shown that the attributes of the people delivering the services in methadone treatment can have a substantial impact. A US study of methadone dose as a factor in outcomes found that the therapist with the best results in the study had 11 per cent of their clients testing positive for opiates (i.e. had used illicit drugs), whilst the therapist with the worst results had 60 per cent positive screens. Retention in services was found by another study to be more associated with therapist differences than with methadone dosage26.
9. Optimal components of methadone maintenance programmes

The research findings in this series suggest that optimal methadone maintenance treatment programmes can be achieved by taking forward developments on a number of fronts. This briefing paper has identified that adequate dosing, flexible individualised dosing regimes and positive client-worker relationships appear to be important components of improving outcomes.

10. Additional information

All briefings, background papers and updates on the NTA’s related work programmes are available online at www.nta.nhs.uk or from nta.enquiries@nta-nhs.org.uk, tel 020 7972 2214.

Models of care, a framework for substance misuse treatment, and the Commissioning standards in drug and alcohol treatment and care are available from the NTA, email: nta.enquiries@nta-nhs.org.uk, tel 020 7972 2214.

Drug and Alcohol Findings magazine provides updates on relevant research and is available from findings@alcoholconcern.org.uk, tel 020 7928 7377.

References


25. See 5.
Series of briefings linking the international research evidence with issues facing drug treatment in England.

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