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Residential Treatment Modifications: Adjunctive Services to Accommodate Clients on Methadone

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Abstract

Background/Objectives—This article describes therapeutic community (TC) services modified to support methadone residents and their service utilization in a study of TC patients (N=231) receiving versus not receiving methadone.

Methods—Service utilization data is reported from providers (i.e., methadone support group counselor, acupuncturist, and consulting psychiatrist) for 12 months after admission. Descriptive statistics are used to report methadone residents use of methadone support group and acupuncture services. Pearson chi-square tests are used to compare methadone and non-methadone participants use of psychiatrist services. Additionally, such tests were used to compare both groups DSM-IV diagnoses.

Results—97% of methadone patients attended at least one methadone support group; 52% used acupuncture services. Proportionally more non-methadone residents used psychiatric services ($p < .05$).

Conclusion and Scientific Significance—Services tailored to methadone residents were accessed by this group. However, while 32% of all participants met diagnostic criteria for a current psychiatric disorder, only 22% received onsite psychiatric care, which questions whether integrated care is being provided adequately for participants with co-occurring disorders.

Keywords

residential treatment; therapeutic communities; opioid replacement therapy; methadone; drug abuse treatment

Residential treatment programs and methadone programs operate predominantly separate from one another, yet share the mission of reducing drug use problems. The therapeutic community (TC) is a residential treatment modality that views the community as the primary agent of change (1), which usually endorses an abstinence-oriented treatment philosophy; use of medications, such as methadone, is viewed as incompatible with recovery (2, 3). A recent national survey found that 7% of TCs integrated methadone maintenance treatment (MMT) within their program (4). Separation of services may be diminishing, as some TCs are re-evaluating their treatment admission policies and recognizing that methadone reduces illicit opioid use, criminal behavior, and the risk for HIV transmission (5–7). Moreover, lack of residential care services offered to participants receiving methadone is an access issue for participants in need of a higher level of care.

TC and methadone treatment program collaborations, though rare, can be found. Passages, an enhanced day treatment program located in New York City and East Meadow, New

York, respectively, used modified TC methods to treat methadone clients (8). Passages membership was associated with reductions in drug use, criminal activity, and psychological dysfunction. Zweben and colleagues (1999) describe a collaboration between a residential treatment program and a methadone program and argue that communication and ongoing education is critical for success.

This article describes services tailored to support TC residents receiving methadone and the extent of service use. We also assessed the prevalence of co-occurring substance dependence and other psychiatric disorders among this sample, and compared methadone and non-methadone groups on their use of psychiatric services and the prevalence of psychiatric disorders.

Methods

Background

This investigation was a sub-study of a five-year comparative investigation of treatment outcomes for TC clients receiving versus not receiving methadone treatment, while in residential treatment. Details on the main outcomes study can be found elsewhere (9). For the purposes of this report, we report on interview data gathered at baseline and on service utilization data received from providers for 12 months after admission.

Measures

Participants were interviewed using both published measures and measures created for the study. The published measures included the Addiction Severity Index (ASI;10) the Computerized Diagnostic Interview Schedule (11), and the MOS SF-36 Short-Form Health Survey (12). To measure service utilization, clinicians (i.e., peer counselor, acupuncturist, and consulting psychiatrist) completed attendance logs of participants who received treatment for the prior month.

Participants

The sample was 145 men and 86 women enrolled in a TC. Fifty-four percent received methadone while in treatment. At study intake, 11% of participants were married with a mean age of 40 years ($SD = 9.8$). Fifty percent were Caucasian, 31% were African-American, 8% were Latino/a, and 11% other/mixed ethnicity. Prior to treatment entry, 24% were homeless and 65% of participants reported that opioid use was their major drug use problem.

Services Tailored to Methadone Clients

Methadone Support Group—Peer counselor-facilitated methadone support groups were held onsite twice weekly. The intent was to provide a “safe” environment where people receiving methadone could discuss methadone specific issues with one another (e.g., stigma about receiving methadone). Attendance at least one group a week was mandatory.

Acupuncture Treatment—Only methadone patients had access to onsite acupuncture treatment, which was limited to two sessions per week. While use of this service was encouraged it was by no means a requirement of TC treatment. However; it could be helpful particularly when residents were tapering from methadone. Although the efficacy of acupuncture for the treatment of opioid dependence has not been demonstrated with randomized clinical trials, some research indicates that acupuncture is a beneficial adjunctive therapy to methadone, particularly with alleviating withdrawal symptoms (13–

15). If non-methadone clients requested acupuncture, they were referred to services in the local community.

Psychiatric Services—Services were provided onsite at the TC by a consulting psychiatrist. All clients, irrespective of whether they were receiving methadone, had the option of receiving such treatment. In addition to the assessment and treatment of other psychiatric conditions, this treatment also permitted methadone participants to seek assistance in managing withdrawal symptoms associated with tapering from methadone.

Methadone Treatment

Prior to TC treatment admission, all MMT participants were being treated in community methadone programs. While in TC treatment, residents were provided transportation to the methadone clinic and accompanied by another TC resident. As part of modified TC care, clients provided written consent to allow their TC and MMT counselors to exchange clinical information pertaining to their treatment. At study intake, the mean methadone dosage was 69.5 mgs. (SD = 47.2; range = 22 to 145). Forty-six of the participants receiving methadone were tapering from their methadone dosage at some point during their TC stay.

Participants reported receiving MMT from a total of 6 clinics with the following characteristics: 65% public non-profit clinics, 33% for-profit clinics, and 2% clinics operated by the San Francisco Veterans Affairs Medical Center. Eighty-nine percent of participants paid for their methadone treatment with public insurance benefits.

During the course of the study, a demonstration grant from the Center for Substance Abuse Treatment supported the development of a mobile methadone clinic (a specially fitted recreational vehicle [RV]). The program developed in San Francisco, CA is similar to other mobile methadone programs offered in cities such as Baltimore, MD (16). In a partnership with the mobile clinic, the TC allowed the RV to use a counseling office and its outpatient program parking lot for dispensing. TC methadone patients could attend the mobile methadone clinic for their MMT.

Data Analysis

Descriptive statistics included demographic characteristics, on-site service use, and the proportion of participants who met DSM-IV diagnostic criteria substance dependence or other psychiatric disorders at baseline. We used Pearson chi-square tests to compare methadone and non-methadone groups on their use of psychiatric services and to compare the prevalence of DSM-IV substance dependence and other psychiatric disorders between groups. We grouped schizophrenia, schizophreniform, and schizoaffective into the category of severe mental illness to assess group differences as the prevalence of such disorders was infrequent.

Results

No statistically significant differences between methadone and non-methadone groups on their socio-demographic, substance use, and physical and mental health characteristics at baseline were found with the exception of ASI drug use severity scores. Participants receiving methadone had higher ASI drug use severity scores than those not receiving methadone [$t(228) = -3.88, p < .001; M = .25$ vs. $M = .17$]. While most participants (84%) had completed TC treatment by the end of month 12, some participants remained in treatment modalities that were part of the TC, such as outpatient treatment (9). Additionally, retention in treatment was statistically equivalent between the methadone and non-

methadone groups, with a mean number of 166.5 days in treatment for the methadone group and a mean of 180.2 days in treatment for the non-methadone group (9).

Methadone Support Groups

A large majority ($n = 121$; 97%) of participants receiving methadone attended at least one methadone support group. The mean number of group sessions attended was 13.7 ($SD = 11.03$; range = 1 to 49).

Alternative Therapy

Fifty-two percent of all methadone participants (65 out of 125) used acupuncture services. Among those who received treatment, the mean number of acupuncture sessions attended was 7.4 ($SD = 7.99$; range = 1 to 36), and the median was 3.

Psychiatric Services

Twenty-two percent of participants (51 out of 231) had a psychiatric visit while in treatment. The mean number of psychiatric appointments was 4.5 ($SD = 3.20$; range = 1 to 14). Participants' current and lifetime substance dependence and other psychiatric disorders are presented in Table 1. The most common lifetime illicit substance dependence was opioid dependence, followed by cocaine, amphetamines, cannabis and sedatives. Among other lifetime psychiatric disorders, alcohol dependence, major depression, posttraumatic stress disorder, and bipolar 1 disorder were common. Among other current psychiatric disorders, posttraumatic stress disorder was most common, and 32% (excluding alcohol dependence) met diagnostic criteria for at least one of these disorders. Regarding opioid dependence, 93% of non-methadone participants met lifetime dependence whereas 82% met current dependence.

We compared methadone and non-methadone participants on their use of psychiatric services; proportionally more non-methadone than methadone participants used services (28% versus 17%; chi-square = 4.41; $df = 1$; $p < .05$). There were no significant differences between groups in the prevalence of lifetime and current diagnoses for illicit substance dependence and other psychiatric disorders (with the exception of lifetime alcohol dependence), including the combined category of severe mental illness. Proportionally more non-methadone than methadone participants met DSM-IV criteria for a lifetime diagnosis of alcohol dependence (64% versus 47%; chi-square = 6.03; $df = 1$; $p < .05$).

Finally, we compared participants who met diagnostic criteria for a current psychiatric disorder (i.e., bipolar I, posttraumatic stress disorder, and schizophrenia) to those without a current disorder on their use of psychiatric services. There was no significant difference between those with and without a current psychiatric disorder in the likelihood of using onsite services ($p = .12$).

Conclusion

This study of adaptations to residential treatment to accommodate residents on methadone found that methadone participants generally used methadone support groups as recommended. Additionally, over half of all methadone participants used acupuncture services. There are no published studies reporting the rate of acupuncture service use among methadone patients, thus it is difficult to evaluate whether this is a high or low rate of use. There are several reports, however, of the use of acupuncture services in methadone treatment, showing mixed results (13–15 17). Methadone patients may have used acupuncture services to alleviate the symptoms of methadone withdrawal or to better cope with psychiatric symptoms. However, an analysis of the prevalence of current psychiatric

disorders among methadone patients revealed that 52% of those who used acupuncture services were not more likely to have a current psychiatric diagnosis than the 38% who did not use acupuncture services ($p = .09$).

With regard to psychiatric services, we found that non-methadone participants were more likely to receive psychiatric treatment than methadone participants. This finding was somewhat surprising, as methadone participants could have potentially benefited from being prescribed medications to ameliorate withdrawal symptoms from methadone tapering. However, it is possible that methadone patients with serious psychiatric conditions may have benefited from the mood stabilizing properties of methadone (18), thus attenuating the severity of psychiatric symptoms.

This sample had high rates of lifetime and current psychiatric disorders and substance dependence. Most notably, 48% of the sample had a lifetime diagnosis of major depressive disorder and 24% of participants had a current diagnosis of posttraumatic disorder. Additionally, 32% of the entire sample met diagnostic criteria for at least one current psychiatric disorder. These findings are consistent with studies demonstrating unusually high rates of other coexisting psychiatric disorders among people in treatment for substance use disorders (21). However, 22% of participants received onsite psychiatric services suggesting that some who needed these services did not receive them while in the TC. Moreover, the finding of no significant differences in onsite psychiatric services received between those with and without a current psychiatric disorder supports the notion that some who needed psychiatric treatment did not receive it while residing in the TC.

The study has limitations that should be taken into consideration in interpreting findings. Participants may differ from TC residents receiving services in other TC settings in unknown ways. We also did not systematically assess how much psychiatric care participants received outside the TC setting, which could have accounted for between group differences. Additionally, 9% of attendance logs were not made available to study staff. Future research with larger samples may also explore the differential response of subgroups, such as TC residents with opiate dependence versus dependence on other substances of abuse.

Implications

Co-occurring psychiatric disorders are highly prevalent in the substance abusing client population (19); however, most substance abuse treatment programs are not well equipped to treat these patients. Although the best practice for clients with co-occurring disorders is integrated care, many barriers exist that prevent substance abuse treatment programs from adopting this best practice approach. Indeed, in order to implement the “no wrong door” policy of the Center for Substance Abuse Treatment (2005), that clients with co-occurring disorders receive efficacious treatment regardless of point of treatment entry, facilitators and barriers to this treatment approach warrant further exploration (20). Nonetheless, with adequate resources for program development and trained staff, TCs may be able to enhance their programs to accommodate such patients.

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Table 1

Lifetime and Current Psychiatric Disorders and Drug Dependencies by Study Group

Characteristic	Lifetime		Current		Lifetime		Current	
	Methadone		Non-Methadone		Methadone		Non-Methadone	
	n	%	n	%	n	%	n	%
Psychiatric disorders								
Alcohol dependence	59	47	12	10	68	64	16	15
Major depressive disorder	58	46	--	--	52	49	--	--
Bipolar I disorder	26	21	17	14	19	18	13	12
Posttraumatic stress disorder	38	30	24	19	41	37	30	29
Schizoaffective disorder	1	<1	--	--	1	<1	--	--
Schizophreniform	4	3	--	--	1	<1	--	--
Schizophrenia	2	2	2	2	3	3	3	3
Drug dependencies								
Cocaine	96	77	58	47	76	72	53	51
Opiates	116	93	92	75	99	93	85	82
Cannabis	30	24	3	2	34	32	6	6
Amphetamine	46	37	14	11	49	46	19	18
Sedative	33	26	9	7	30	29	9	9
Phencyclidine	4	3	--	--	7	7	1	<1
Other hallucinogens	13	10	--	--	19	18	--	--