A LOW THRESHOLD METHADONE PROGRAMME

Flexible, accessible, attractive—that's what government and their advisers say addiction clinics should be to counter HIV. At Northern Road they've thrown out the waiting lists and detoxification timetables and let the clients set the goals.

Philip Fleming

THE ADVENT OF AIDS has led to drug services having to look in a new light at what they are providing. The priority now is to get in touch with drugtakers, particularly those at risk of contracting and spreading HIV infection, to encourage them into 'treatment' and to move them to less risky drugtaking as a first step on a road leading ultimately to abstinence.

In Portsmouth we have developed a methadone programme which meets some of these requirements. The development of this programme should be viewed against the background of an already well-staffed, comprehensive range of services in the area. One of the few drug clinics then outside London was set up in 1967 at the local psychiatric hospital. Alpha House, the first residential rehabilitation programme for drug users in Europe, began its days in that same hospital a year later.

In the 1970s an outpatient prescribing clinic was the main focus, becoming more community orientated with the appointment of a community nurse in 1976. Methadone prescribing was tightly controlled. Users usually had to be assessed as inpatients for a few days and were supervised daily during the early weeks of their prescription. However, unlike other clinics at the time, there were no fixed reduction programmes. Users were encouraged to reduce their prescriptions, but it was accepted that some might need to be on methadone for longer periods.

With specific funding for drug services available from 1983, the service has expanded considerably. There are now the equivalent of 15 full-time staff, including nurses, a social worker, a psychologist, doctors and secretarial staff. Since 1985 the service has been based in the community at the Northern Road Clinic. This acts as a drop-in centre, a base for staff, and the location for therapeutic activities including counselling, group work, outpatient clinics, and the methadone programme.

In addition, drop-in 'satellite' centres have been set up around the district, run by clinic staff or volunteers, and in some cases helped by the probation service. Since 1987 a needle exchange has operated from a health centre in Portsmouth, more recently extended to a second location. Also in 1987 a purpose-built ten-bed inpatient unit was opened next to the Northern Road Clinic.[1]

Lowering the threshold

Despite this comparatively well-equipped service, in April 1987 a number of factors led to a change to a new style of methadone programme.

- Staff were dissatisfied with the confrontational style of management of methadone clients. This fostered deceit by the client and collusion by the therapist. For example, the 'rules' stated that those on methadone should not use illicit drugs, yet staff turned a blind eye to this until some crisis occurred, when clients would be threatened with a forced reduction unless they stopped using extra drugs. Numerous manipulative games developed between staff and users that prevented any productive work together.
- Two pieces of research involving interviews with users revealed considerable dissatisfaction with the then methadone programme.[2, 3] Clearly, customers found that aspect of the service distinctly unfriendly.
- Several members of staff attended a seminar by a psychologist running a methadone programme in Holland using motivational interviewing.[4] This seemed a much more positive approach.
- Although the service was seeing one in four or five of the local heroin using population,[3] growing concern about HIV infection indicated that we had to attract more users.

The low threshold programme was developed in response to these concerns. Most opiate using clients are self-referred and are seen by a staff member on arrival at the clinic. There is no waiting list. A full history is taken and a urine test. If the negotiated treatment is for methadone, providing there is evidence of recent regular opiate use, a prescription can be arranged on a provisional basis that day. The decision is reviewed at a weekly multidisciplinary staff meeting. The maximum dosage for all stages of the programme is 50mg of oral methadone mixture; no injectables are prescribed.

Initially the client has to attend four mornings a week to drink the methadone in front of a member of staff. (Arrangements are made with a retail pharmacy for those who cannot attend daily to drink their methadone in front of the pharmacist.) After this they pass through a room where other clients and therapists are sitting informally, drinking coffee. Clients are encouraged, but not pressurised, to stay; most do so.

It is in this setting that motivational interviewing starts,[5] in essence a client-led process aimed at helping clients identify and share concerns about their problems and to reach decisions about making changes in their lives. Each client has a case manager who sees them individually as appropriate.

During this supervised stage we accept that clients may use additional drugs and do not test their urine. Once clients feel confident enough not to use other drugs, they may pick up their prescription from a pharmacist and take it unsupervised. At this stage we expect them not to supplement their prescription and urine tests are done; if there is persistent evidence of other drug use the client has to return to supervised methadone.

There is no fixed reduction programme, as clients are encouraged to make decisions about reduction or admission for detoxification themselves. They are responsible for their own drug use and they set the goals, not the staff.

Staff and clients both much prefer this new system. Relationships between them are much improved and this has benefited the work of the clinic as a whole. There is considerably increased client contact and supervision during the early stages of the programme, and therefore more opportunity to influence motivation. The number of opiate users coming to the clinic has doubled. In particular, longer term users not previously in contact with services have come forward. Users referred via the needle exchange can be taken on without delay.

It is important to see the low threshold methadone programme as part of an integrated district drug service. Methadone is only one option among several available to our clients. The acceptability of the service to drug users and the relative ease with which they can get into treatment are important harm-minimisation benefits. However, this success has entailed a significant increase in staff workload, only slightly mitigated by better working relationships with clients.

QUESTIONS STILL REMAIN. Although we are seeing a throughput of clients, with evidence of a reduction in risky behaviour and others coming off their drugs, we do not know whether this type of approach is any more effective than others.[6] There is a pressing need for comparative research. The success of the programme in attracting clients has brought an increasing number of injecting amphetamine users to the service. We do not know how best to deal with these, and they are likely to pose a greater challenge to services than do opiate users. ■

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