

***IN THE SPOTLIGHT***



## **Making Residential Treatment Available to Methadone Clients**

OAKLAND, CALIFORNIA

**Abstract**-This article addresses challenges to integrating clients on methadone into residential treatment, with the goal of promoting greater access for this population. It describes the basic administrative conditions needed for success, and discusses barriers and problems within the methadone program and the residential program. Staff communication, procedures for coordination, client and staff attitudes and understanding, and ongoing education are seen as the key to creating an environment conducive to success for the client. ©1999 Elsevier Science Inc. All rights reserved.

**Keywords**-drug abuse treatment; heroin addiction; Medicaid; methadone; residential treatment therapeutic communities.

---

### **INTRODUCTION**

Supported by grant no.5 HD8 n00648-05 from the Center for Substance Abuse Treatment.

We wish to express our appreciation for the financial and other forms of support provided by the Center for Substance Abuse Treatment, which permitted us to go beyond traditional barriers and offer this demonstration that methadone patients can be effectively served in residential treatment. We would also like to thank Project Pride's evaluator, Dr. George DeLeon, and his staff at the National Development Research Institute in New York for their assistance since the inception of this project.

Requests for reprints should be addressed to Joan E. Zweben, PhD, 714 Spruce Street, Berkeley, CA 94707.E-mail:jzweben@itsa.ucsf.edu

METHADONE PROGRAM STAFF have typically endured many years of frustration when trying to gain access to residential treatment for their patients. Although many methadone patients are able to use outpatient treatment to transform their lifestyle, there is a subgroup in need of the major rehabilitative effort that therapeutic communities (TCs) can provide, or the protected living situation of less structured residential settings. Staff members seeking access for their patients meet with a variety of resistances. Sometimes the program does not admit any-

one on medication. At other times, methadone patients are excluded because methadone in particular is viewed as incompatible with recovery (Zweben, 1997; Zweben & Payte, 1990; Zweben & Sorensen, 1988). Recently, there has been some softening of attitudes, due to the recognition of the high frequency of clients with dual disorders, for whom psychotropic medications enhance the likelihood of success. Slowly, policies about methadone are being reconsidered, in part because of the evidence conflicting that long-term maintenance will be necessary for many methadone patients (Lowinson, Marion, Joseph, & Dole, 1992; Parrino, 1993), and partly due to its documented usefulness in slowing the spread of AIDS (Ball, Lange, Myers, & Friedman, 1988). Further progress has been made due to efforts to reduce discrimination as required by the Americans with Disabilities Act. Discrimination against people on medication is not permitted if reasonable accommodation is possible. Government agencies are addressing access barriers in their contracts with programs and obstacles are diminishing gradually.

Although the climate is more receptive, many problems remain. Residential programs range widely in sophistication, and some have little or no experience in dealing with medication and related matters. Issues such as safe storage, monitoring patient doses, and collaboration with physicians and methadone programs are all areas of inexperience; hence the transition is intimidating. Other programs are accustomed to handling some kinds of medication, but view methadone as outside the boundary of what is acceptable. It is not advisable to introduce clients on methadone into many residential programs because of the attitudes of staff, the other clients, and the methadone clients themselves. Tapering off methadone is often seen as necessary to be "really in recovery" or to be seen as a success. Decades of stigma and misinformation cannot be easily eliminated. Proper preparation is essential to make the residential experience productive for the methadone patient.

### THE PARTNERS

In this article, we describe collaboration between a methadone program (The 14th Street Clinic) and a TC (Project Pride, East Bay Community Recovery Project) to make this intensive form of treatment available. The 14th Street Clinic is a methadone program in Oakland, California, launched in 1979. It maintains a census of about 400 clients on methadone or levo-alpha-acetylmethadol (LAAM), and offers heroin detoxification as well as other services. Project Pride is the residential treatment component of the East Bay Community Recovery Project, also in Oakland, California. It is a TC for mothers and their children, originally funded as a National Treatment Demonstration Project by the Center for Substance Abuse Treatment (CSAT; grant no.5 HD8

TIO0648-05). For most of the period described in this article, there were 15 to 18 mothers and 15 to 20 children present in the program. The CSA T grant provided a means to include methadone patients in the residential program, identify the problems likely to be encountered by others as well as us, and seek solutions. Our experience is offered to make it easier for others to undertake this task, and hopefully encourage more to do so.

### TREATMENT MODALITIES: COMPARISONS AND CHALLENGES

Methadone programs and TCs typically have many differences that can pose obstacles to collaboration. Although there is variability within both systems, certain contrasts can be expected. Outpatient and residential programs have some dimensions on which they usually (but not always) differ. Outpatient programs usually serve a wider range of clients and rely on engagement efforts to retain clients in treatment. The stern confrontation characteristic of many TCs would alienate many outpatient clients and increase early dropout. Residential beds are scarce in most communities, and admission policies are much more selective. They usually include clarification of program rigors, so that entering clients expect greater demands.

Some distinctive features are particularly characteristic of methadone programs. A major philosophical difference has to do with the blending of harm reduction and abstinence-oriented recovery models in many methadone programs; TCs typically endorse abstinence goals. A typical methadone program will have patients strongly committed to ceasing illicit drug use and changing lifestyles, and others engaged in some form of harm reduction, in which they seek to reduce their drug use to less disruptive levels. The well-documented public health benefits of retaining these patients in treatment (Ball & Ross, 1991; Gerstein & Harwood, 1990; Hubbard et al., 1989; Vocci, 1990) supports the practice of retaining both subgroups in most programs. Illicit drug use results in loss of privileges and other consequences, but discharge is generally viewed as inappropriate (Payte & Khuri, 1991a). TCs do not have this luxury. As residential programs, they must usually discharge active users to keep the environment safe for other residents, even if their philosophical position allowed for flexibility in an individual case.

Many dimensions of this problem stem from more general differences between outpatient and residential treatment. Successful outpatient programs understand the importance of retention (in relation to improving outcome), and focus on strengthening the therapeutic alliance as a way of achieving this. Inasmuch as the misbehavior of one client does not usually impact many others in the program, outpatient programs can be more permissive during periods of client acting out. Time perspec-

tives differ, not only between outpatient and residential, but between methadone programs and other outpatient modalities. Since methadone programs usually retain patients for many years, the counselor has less of a sense of urgency about when goals need to be accomplished. TC staff members are usually keenly aware of time pressure, especially as lengths of stay become shortened due to funding constraints.

Residential programs have a more complex context for their clinical decision-making. Clinical decisions need to take into account not only what is best for the individual client, but the possible negative impact on others, all of whom are more likely to be affected because they share living space as well as most program activities. Leniency about a particular behavior may be beneficial or at least not harmful for the individual client, but can have negative repercussions throughout the program as a whole. TCs are, in general, highly structured, and unless outpatient staff have worked in them, the reasons for certain practices are not understood and may be seen as punitive. For example, the isolation of the client during the first 30 days is often seen as punitive by those who do not understand its function of breaking the ties to the street and bonding the client to the community. The level of confrontation in the TC is sometimes seen as too harsh and restrictive by the methadone program counselors. Thus, staff in both programs may view each other with mistrust and be highly critical of each other's practices. For clients so inclined, this is fertile ground to manipulate and divide staff.

Admission criteria, processes, and barriers are usually quite different. Once federal and state admission requirements have been met, methadone programs are typically inclusive, admitting patients with wide variability in their level of functioning. TCs, with their limited beds, usually have much more stringent criteria, and take great care to admit clients capable of meeting its rigorous demands. Patients can be admitted relatively rapidly into the methadone program, whereas TC clients usually spend weeks and often months waiting for admission.

The therapeutic alliance and allegiances also vary between the two systems. In most outpatient programs, the strongest alliances are usually to staff members, particularly the individual counselor. In TCs, great effort is made to bond the client to the community, which is seen as the primary agent of change (DeLeon, 1997). Peer pressure is more pronounced in the TC as a way to modify attitudes, beliefs, and behavior. These differences have consequences that will be explored later.

### STAFF INTERACTIONS BETWEEN THE TC AND THE METHADONE PROGRAM

Most states have complex methadone licensing procedures and it is often unrealistic to expect residential programs to obtain a license to dispense methadone or other

opioid maintenance medications. Thus, collaboration between the methadone program and the residential program is a key element in the success of this venture. In this particular venture, most of the methadone clients were served by the 14th Street Clinic, but others were accepted into the program for a time.

The very existence of two distinct programs, as well as the other differences between them, sets the stage for breakdowns in communication. Certain clients have well-honed skills at splitting staff and addressing the resulting problems can be very time consuming. For example, it is not hard to present TC practices in a harsh light, even when they are skillfully and supportively implemented. Methadone clients, accustomed to individual attention, may resist the assimilation into the treatment community that makes the TC experience powerful. This is exacerbated by their "differentness" by virtue of being on methadone; other TC clients and staff may reinforce the idea that they are somehow not fully a part of the TC "family."

It also may be tempting for staff to focus on client-splitting behavior, rather than systemic breakdowns in communication between staff. It is useful for the staff to look first at possible communication inadequacies, as this reduces the likelihood of the client being pathologized or scapegoated for what is in fact haphazard communication between two agencies.

Janice was referred to Project Pride by her clinic in San Francisco, and transferred her methadone services to 14th Street for the duration of her residential stay. Although she badly needed the structure of the therapeutic community, she expended considerable energy in rebellion. She insisted the dose at which she could be comfortable was just above the level permitted for take home exceptions, thereby assuring she would have to travel daily to the methadone program and could avoid group sessions and other activities in the TC.

Once at the methadone program, she spent an enormous amount of time hopping from staff person to staff person, talking about a variety of issues. In particular, she presented her concerns about her health problems as if no one in the TC were addressing them, thus escalating the staff polarization.

As time went on, 14th Street and Project Pride tightened their communication and the time structure for Janice. It emerged that her complex health problems were being appropriately addressed. While at 14th Street, she was allowed access only to her counselor, who made other referrals as needed. For a time, 14th Street would notify Project Pride once, she had dosed, so that she could be held accountable for reasonable travel time.

After this restructuring, Janice's behavior at the methadone program became less disruptive. She went into a training program at the community college and eventually reunified with her husband and child.

Serendipity produced a valuable intervention in the early stages of our collaboration. A 14th Street staff member took a part-time job at Project Pride, and for 18 months served as a bridge between the two programs.

She was able to correct misunderstandings based on lack of knowledge about the other modality, and to encourage rapid checking out of divisive rumors. It is possible that creating a position in which part time would be spent in each facility would be a good ongoing solution.

### Medication Issues

Methods by which the methadone dose is established, monitored, adjusted, and delivered are all key issues around which problems can develop. In this collaboration, we were fortunate to have these problems simplified, because we are affiliated agencies with the same Executive Director and Medical Director, both of whom are strongly committed to this endeavor. However, even with these advantages, the challenges are daunting.

The delivery of the methadone dose is a key issue that influences how disruptive medication dosing is to the program. From the perspective of the residential program, it was helpful to have dosing on site, so clients did not have to leave the facility and miss activities in order to get their dose. In the early stages of this collaboration, regulatory restrictions made this highly problematic. Eventually, the state revised its regulations so that onsite dosing could be provided, but this kind of obstacle may exist in other states.

Although doses can be administered to a stabilized client at Project Pride, induction and dose adjustments require frequent trips to the clinic so that the staff of the methadone program can observe and discuss progress with the client. This can generate conflicts between the methadone program staff, who understandably feel greater expertise, and the Project Pride staff who may feel the dose is already too high or otherwise incorrect. Some clients behave in ways that exacerbate these divisions, blaming methadone effects for their difficulty in participating fully or appropriately in the residential program activities. Ongoing case conferences about the shared clients were helpful in decreasing these conflicts. In these meetings, Project Pride staff were able to learn about methadone and ask specific questions related to their clients. The 14th Street staff were able to ask about their clients' participation and progress in the TC. Clients entering Project Pride from clinics other than 14th Street posed other kinds of problems. Despite a widely disseminated research literature confirming that the effective therapeutic window for methadone is 60 mg-100 mg (Payte & Khuri, 1991 b), several local clinics maintain "low dose" policies. These clients often needed a dose increase, which could not be accomplished without transferring the client to 14th Street. Other clinics were also not always willing to arrange for doses to be administered at Project Pride. Having a client travel by bus was time-consuming and often disruptive of program activities. Project Pride staff transporting the client to an outside clinic was often expensive, impractical, and sometimes impossible. The collaborative effort quickly becomes

burdensome as additional methadone programs are added. Over time, it proved simpler to transfer the clients to 14th Street for the duration of their residential stay, and then transfer them back to their original "home" clinic afterward.

### REGULATORY AND FISCAL ISSUES

Security of the methadone was a central concern. Inasmuch as the number of methadone patients at any given time was relatively small (up to four patients at a time), many of the same procedures were used for methadone as for psychotropic medications. The client went to 14th Street once a week, and received six take-homes in a locked box for which the client held the key. (This was made possible by state exception to the take-home regulations, which ordinarily required longer times free of illicit drugs before take-homes were given.) The locked box was put into a locked closet in a locked office (restricted access) at Project Pride. TC staff had keys to both the office and the closet. At the appointed time, the client would open her box and take her medication under observation of a Project Pride staff person, who would record the event in a designated log. This type of procedure, common to many residential programs, allows for careful medication monitoring without staff becoming involved in actual dispensing, for which special credentials and licenses are needed. It also made it easier to split the methadone dose and offer it twice daily than it is when the client is an outpatient without take-home privileges.

Inasmuch as the methadone program remains responsible for the security of the methadone, it is important that the residential program staff notify them immediately in the case of a breach. For example, if a woman in transit with her week's take-home medication chooses that opportunity to exit the residential program, it is necessary for the methadone program to be notified immediately. Residential program staff are not typically aware of the high level of monitoring and security needed in the handling of methadone, and may overlook this type of communication when coping with the upheaval of a woman leaving the program abruptly. It is important that residential program staff be carefully trained in all aspects of relevant law and regulations pertaining to methadone.

Reimbursement continues to be a major problem. In California, it is tied to face-to-face visits at the methadone program. This means that modifications made to enhance participation in the residential program had negative fiscal consequences to the methadone program. Although the bulk of therapeutic intervention occurred at the residential program, methadone program involvement was needed both for clinical continuity and regulatory requirements. For example, much effort was expended on the part of the methadone program counselors to encourage clients to remain in Project Pride when the

going got rough. Considerable staff time was expended formulating strategies. Thus, there was little compensation for the clients who, in fact, required the most attention. States wishing to encourage elimination of barriers for methadone patients need to carefully attend to these fiscal obstacles.

An additional problem arose when Medi-Cal (Medicaid) funding for methadone slots was limited and waiting lists were long. Clients sometimes sought a back-door admission to a Medi-Cal slot in the methadone program by entering Project Pride, and then dropping out quickly. A policy was thus devised that when a methadone client left Project Pride, she had 30 days to find a Medi-Cal slot in the community or pay private fees to remain at 14th Street.

### **CLIENT INTERACTIONS WITH THE METHADONE PROGRAM**

The orientation stage of TC treatment is designed to disrupt the ties to the outer environment and build the bonds to the TC, which will be the primary change agent for that time. Physical isolation is a key element that permits this to happen. However, clients entering both programs simultaneously, such as women emerging from jail and admitted immediately to both programs, may need to travel to 14th Street for the time needed to stabilize them at the appropriate dose, usually about a month. These clients are not insulated from the outside world, and must face some of their triggers daily. They reported it was harder to get focused at Project Pride, and they did not feel the same sense of safety. Some encountered people they have used drugs with when they went to the clinic to receive their dose. Others seized the opportunity to arrange trysts in the clinic parking lot, unauthorized shopping expeditions, and detours to the beauty shop. No matter how much care was taken to move them in and out quickly, one could count on an unlikely coincidence to produce a difficult incident. The methadone clients did not get the same insulation from the outer community, and we believe this may be related to some of the early treatment dropout.

### **MISINFORMATION AND NEGATIVE ATTITUDES ABOUT METHADONE IN THE TC**

Although there is considerable variability among individuals, both clients and TC staff have all of the usual misconceptions about methadone. This was often reinforced by their own negative experiences in methadone treatment. Some staff believe that clients on methadone are not clean or are not in recovery, and exert subtle and overt pressure for them to taper off. Staff may assume that tapering off methadone is primarily a question of motivation and commitment to recovery-related activities, and expect clients to taper off during their residen-

tial stay because it is a supportive environment. Some believe methadone clients are still getting high. Clients who were not on methadone felt that the methadone clients received special privileges. Being on methadone served as a scapegoat for a host of behavioral problems. Staff and clients attributed a client's acting-out behavior, resistance, anxiety, or depression to the methadone. Unfortunately, most of the methadone clients did in fact have more medical and psychiatric problems than their counterparts.

Both clients and staff have misconceptions about dose and are suspicious of dose increases. Methadone clients themselves often feel they are not as good as others who do not need medication, or they have failed if they cannot discontinue it. Although many of these feelings occur with psychotropic medication, they are usually much more intense about methadone. Addressing these misconceptions should be viewed as an ongoing project, partly because of staff turnover and partly due to the time needed to really change underlying attitudes so that new information can be absorbed.

Another source of negative attitudes toward the methadone clients arose from the perception that they were more difficult and disturbed. The view was confirmed by the evaluation data discussed later in this article. Indeed, Project Pride was referred a select group, methadone clients who did not improve in outpatient treatment. They were sent because they remained out of control despite repeated outpatient treatment interventions:

Rachael did so poorly at 14th Street that staff were concerned she was on a suicide mission. She became pregnant and did not want the baby. She continued to use drugs and did not keep appointments with her obstetrician or with 14th Street staff. She was referred to Project Pride with great pessimism about her ability to respond positively. In fact, she did well once she adjusted. She developed great interest in her baby and benefited from the structure of the TC.

Thus the very reason these clients need access to residential treatment can lead to a negative view of their prospects if care is not taken to prepare the TC staff to handle their transition carefully. Many resist the structure they so desperately need, but make satisfactory adjustment and good progress later.

### **STAFF ATTITUDES AND EDUCATIONAL NEEDS**

A key element in the success of the collaboration is wholehearted support and commitment from top management. This created a context in which there was an assumption that problems would be worked on until they were resolved, rather than the project abandoned because of the obstacles. Management worked together to insist that rumors were checked out quickly and escalation of drama was discouraged. Over time, various forms of teamwork were developed between both staffs. Tensions

were reduced once monthly meetings were initiated to discuss the treatment plans and progress of shared clients.

Educational efforts were also important. The methadone program received training on TC, particularly about some of the practices they viewed as alien or uncomfortably coercive. The residential program received training on methadone treatment, a particularly complex endeavor, since many staff had negative experiences with it, including having tried it unsuccessfully themselves. These training sessions needed to be repeated periodically because of staff turnover, and also because different questions emerged as they worked with specific clients. These discussions led into issues about the psychotropic medication many clients were receiving, and the explorations led to modifications in procedures as well as deepening of understanding.

A major advance occurred when Project Pride staff attended the American Methadone Treatment Association conference in Phoenix, Arizona in 1995. They found the educational presentations valuable and responded to the warmth and vitality of the atmosphere. The size of this conference and the presence of many researchers and leaders from state and federal government did much to dispel the perception that methadone treatment was somehow less respectable than other modalities. The two staffs mingled at the conference and both felt it was a turning point in their work together.

### ISSUES ARISING IN GROUPS

The issue of mixing methadone patients with others in groups has been controversial, with few programs considering it, much less experienced in doing so. One of the authors has run a mixed recovery group for more than 12 years, and is satisfied that the problems are quite soluble if the staff attitudes are positive and their interventions constructive. Training for both staff and clients in the TC is essential to further understand the problems and develop sound solutions.

"Nodding out" behavior is one of the most highly charged issues. Methadone clients, once sedentary, may appear to abruptly doze off, in a manner that heroin users clearly distinguish from napping. Many of the staff and other clients who have been on methadone at one time find this behavior highly disturbing. Several possibilities must be considered. Some clients may be on doses that are too high for a life circumstance that is less active than that of the streets, and may need a dose reduction for that or some other reason. Some group activities may promote sedation in methadone patients and others. When consulted about the "nodding out" behavior, the Medical Director discovered that the group leaders were beginning the morning group with deep breathing and other relaxation exercises. She suggested something more aerobic instead. It is also possible that the issue is one of how the behavior is labeled. Clients on methadone may be described as "nodding out," while others exhibiting similar behavior are described as "spacing out, dozing, or tuning

out." Factors such as having just eaten or not having slept might be taken into account for others, but the medication was quickly blamed in the case of methadone clients.

It is important to recognize that the client may be on a completely appropriate dose and exhibit sedation when seated for periods of time. This is variable among individuals, and often motion, such as standing up and moving a few steps during the group (e.g., walking around the chair) or using a wet washcloth eliminates the nodding behavior. Some clients may be less sedated in the morning if their doses were split and taken twice daily. Careful assessment is needed, and it is important that the client remain responsible for seeking ways to maintain appropriate participation by using available remedies and tools. Otherwise, they may feed the negative dynamics by remaining passive and attributing their difficulties to the methadone.

### THE METHADONE CLIENT GROUP

A special group for methadone patients allows some issues to be addressed more effectively. Our collaboration benefited from having a group leader who was once on methadone and successfully tapered off. A client currently on methadone would have also been appropriate to accomplish the goals of the group. It is essential that the leader of such a group is able to view client success in terms of level of functioning, and not whether he or she remains on methadone or discontinues it. Clients need to engage in rigorous self-examination on this issue, with a keen eye for unrealistic expectations. This group gives the methadone clients a chance to air their own special issues, including their feelings of being different from others in the community and the temptation to use methadone to manipulate their way out of challenging situations. This group likely plays an important role in improving retention of the methadone clients in the TC. It is important to have three or more methadone clients in the community at any given time, to make such a group possible and to reduce the isolation that would otherwise be problematic with a smaller number.

### CLIENTS WISHING TO TAPER OFF METHADONE

Methadone clients who enter Project Pride wish to take advantage of the firm support structure to taper off methadone. Although this is certainly a legitimate goal, it has many inherent problems. Some clients decided to taper soon after entering Project Pride, and staff, initially seeing this as positive, did not raise important questions. It also eventually emerged that some staff, despite training efforts on this issue, still believed getting off methadone was always a good thing and encouraged it. Thus, the client was adjusting to the rigors of the TC while also coping with declining methadone dose. Clients reported insomnia, fatigue, exhaustion, agitation, and other symptoms that interfered greatly with their ability to partici-

pate in the activities of the residential program. Staff, unfamiliar with the trials of tapering, struggled to understand what were legitimate requests for "exemptions" and what were not.

To forestall or address these issues, it is important to formulate a tapering policy. This policy should be developed with full knowledge of the literature indicating that most of the patients who qualify to be on methadone or other opioid agonists will not be able to sustain their gains if they discontinue their medication (Payte & Khuri, 1991a; Zweben & Payte, 1990). The policy should describe how the decision actually gets made and who participates in this process. An assessment of client readiness to taper off should include consideration of length and severity of previous heroin use and results of previous efforts to taper off. It is particularly important to assess the extent to which the client's motivation is internal, or a reaction to the attitudes of those around them. It is important to explore feelings of shame, their understanding of methadone, and how their significant others view the situation. Are they trying to fit into a recovery model that says people on medication are not 100% clean? Are they responding to peer pressure?

In the early stages of our program, a 32-year-old long-term heroin user who had been in and out of jail and who had delivered her most recent child while using heroin, was placed on methadone maintenance. Project Pride staff encouraged her to taper off 2 months before leaving, against the advice of the physician and the methadone program staff. She relapsed within a month, and resumed methadone treatment. This episode highlighted the importance of education and clear policies about tapering.

Most of the methadone clients had not accepted the severity and chronicity of their addiction and wanted to taper. They were under pressure from both family and friends. In one case, a woman's husband told her she could not come home because "she wasn't clean." He had once been on methadone and continued to use heroin, then discontinued heroin without medication. Thus, client and family education is important, as is self-examination.

The timing or phase of the residential program is an important factor in reducing some of the disruption and promoting a more successful experience for the client. It is usually not desirable for clients to attempt a taper during the first 3 months, when they are adjusting to the rigors of the TC. It also did not seem useful to taper in the last 3 months, when termination issues were in the foreground. Tapering clients may need to be excused from groups, kitchen duty, and other activities. At present, Project Pride staff have concluded that if tapering is to be attempted at all, it should be in the middle of the program rather than close to the beginning or the end.

### EVALUATION DATA

The evaluation data comparing women on methadone with those who were not indicated that early treatment

dropout (30 days and 90 days) was comparable between the two groups. However, retention rates are lower for women who were on methadone at 6 and 9 months. Women on methadone have lower rates of completion than other clients and were more likely to transfer into other treatment programs. Thus, efforts need to be directed to retaining clients in the program after the initial adjustment stages.

Clinical staff perceived the methadone clients as being more disturbed than the others, and this was confirmed by the evaluation data. Psychological data from the Symptom Checklist-90-Revised (SCL-90-R) at intake showed that methadone clients reported higher levels of distressing symptoms. The strongest relationships were on the scales measuring obsessive-compulsive, anxiety, paranoid ideation, and hostility. There were also significant differences on the somatization, phobic anxiety, and psychoticism scales. The global severity scale was significantly higher for the methadone clients. The higher dropout rate is consistent with the TC literature documenting the relationship between high levels of psychopathology and dropout (DeLeon, 1988; National Development and Research Institutes, 1994).

We believe these findings are consistent with our clinical impression that the methadone clients were more disturbed than the other clients in the residential program. Entering methadone treatment brings significant relief and improvement to most heroin users. It is plausible that those who need residential treatment represent a subgroup at the far end of the spectrum, those whose treatment needs are more complex and whose ability to withstand the rigors of residential treatment is diminished.

### SUMMARY OF RECOMMENDATIONS

#### Between Programs

- Develop support and commitment from top management of both programs.
- Encourage each staff to visit the other program.
- Attend vigilantly to communication pathways within and between the programs.
- Educate on the differences between outpatient and residential treatment.
- Create vehicle for coordination of treatment plans between the two programs.
- Move swiftly to address divisive rumors.
- Employ recovering and nonrecovering staff in both settings.

#### In the Methadone Program

- Provide presentations on therapeutic communities to the methadone program staff.
- Assist staff in relinquishing the client to the residential program while remaining involved in appropriate ways.
- Review issues relating to the security of the methadone regularly.

- Review procedures to insure compliance with methadone regulations while the client is in residential treatment.
- Explore the possibility of having once counselor handle all methadone clients in the residential program.

†East Bay Community Recovery Project,  
Oakland, CA

‡Department of Psychiatry,  
University of California, San Francisco, CA

### In the Therapeutic Community

- Provide regular educational presentations on methadone to clients and staff of the residential program.
- Provide a staff focus group every quarter, in which issues related to methadone clients can be discussed. Create an atmosphere where it is acceptable to ask basic questions and explore biases.
- Employ some counselors in the residential program who are on methadone and who are current in their understanding of opioid pharmacotherapy.
- Include a sufficient number of methadone patients that group activities are possible and isolation is reduced.
- Reduce/eliminate as much disruption as possible by housing the methadone on the site of the residential program.
- Formulate a tapering policy based on sound principles.

### CONCLUSION

Our experience and our data suggest that methadone patients who are willing to enter a TC are a difficult and complex group. They may bring expectations that are sometimes incompatible or difficult to shift, and their clinical complexity appears to be greater. While some of the problems could be simplified by populating the residential program exclusively with methadone patients, this would not broaden access nearly as much as making it possible for a methadone patient to enter any existing residential program in his or her locale. Communication and ongoing education are key elements in success. Creating good teamwork between such distinct cultures as the methadone program and the TC is a challenging task, well rewarded by the appreciation and progress of the clients for whom it is effective.

Joan E. Zweben, PhD\*†‡

Tanya Aly, PsyD†

Judith Martin, MD\*†

Susan Wengrofsky, MA\*

Joanne Bacci\*

Robert Meddaugh, MS\*

\*The 14th Street Clinic,

Oakland, CA

### REFERENCES

- Ball, J., & Ross, A. (1991). *The Effectiveness of methadone maintenance treatment*. New York: Springer-Verlag.
- Ball, J.C., Lange, W.R., Myers, C.P., & Friedman, S.R. (1988). Reducing the risk of AIDS through methadone maintenance treatment. *Journal of Health and Social Behavior*, 29,214-226.
- DeLeon, G. (1988). *The therapeutic community: Enhancing retention in treatment* (Final report on NIDA grant no. R01-DA3617). New York: National Development and Research Institutes.
- DeLeon, G. (Ed.) (1997). *Community as method: Therapeutic communities for special populations in special settings*. Westport, Conn: Praeger.
- Derogatis, L.R. (1997). *SCL-90-R: Administration, scoring and procedures*. University, Clinical Psychometrics Research Unit.
- Gerstein, D.R., & Harwood, H.J. (1990). *Treating drug problems* (Vol. 1). Washington DC: National Academy Press,
- Hubbard, R.L., Marsden, M.E., Rachal, J.V., Harwood, H., Cavanaugh, E.R., & Ginzburg, H.M. (1989). *Drug abuse treatment: A national study of effectiveness*. Chapel Hill: The University of North Carolina Press.
- Lowinson, J.H., Marion, I.J., Joseph, H., & Dole, V.P. (1992). Methadone maintenance. In J. Lowinson, P. Ruiz, R.B. Millman, & J.G. Langrod (Eds.), *Substance abuse: A comprehensive textbook* (pp. 550-561). Baltimore, MD: Williams and Wilkins.
- National Development and Research Institutes. (1994). *Readiness for drug treatment: An assessment instrument* (Final report on NIDA grant no. R01-DA07377). New York: National Development and Research Institutes, Inc.
- Parrino, M. (Ed.) (1993). *State methadone treatment guidelines. Treatment improvement protocol no.1*. Rockville, MD: U.S. Department of Health and Human Services.
- Payte, J.T., & Khuri, E. (1991a). Treatment duration and patient retention. In M. Parrino (Ed.), *State methadone treatment guidelines. Treatment improvement protocol no.1* (pp. 119-124). Rockville, MD: U.S. Department of Health and Human Services.
- Payte, J.T., & Khuri, E.T. (1991b). Principles of methadone dose determination. In M. Parrino (Ed.), *State methadone treatment guidelines* (pp. 47-58). Rockville, MD: U.S. Department of Health and Human Services.
- Vocci, F. (1990). *Death rates in treated and untreated heroin addicts*. Rockville, MD: National Institute on Drug Abuse.
- Zweben, J.E. (1997). *Community, staff and patient perceptions and attitudes*. Paper presented at the Effective Medical Treatment of Heroin Addiction, William H. Natcher Conference Center, November 17, National: Institutes of Health, Bethesda, Maryland.
- Zweben, J.E., & Payte, J.T. (1990). Methadone maintenance in the treatment of opioid dependence: A current perspective. *The Western Journal of Medicine*, 152,588-599.
- Zweben, J.E., & Sorensen, J. (1988). Misunderstandings about methadone. *Journal of Psychoactive Drugs*, 20,275-282.