

GAO

Testimony



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PRELIMINARY FINDINGS:

A Survey of Methadone Maintenance Programs

Statement of
Janet L. Shikles, Director of
National and Public Health Issues

Before the
House Select Committee on Narcotics
Abuse and Control
House of Representatives



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SUMMARY

GAO is reviewing treatment provided by methadone maintenance clinics to heroin addicts for the House Select Committee on Narcotics Abuse and Control.

Methadone is an orally administered, synthetic narcotic used in the treatment of an individual dependent upon heroin or other opiate drugs. More recently, methadone clinics have been confronted with treating patients who abuse multiple drugs. Last year about 100,000 persons were in methadone treatment.

Federal regulations require that methadone maintenance treatment combine the administration of the methadone drug with rehabilitative services to address the physical, psychological, and social problems of heroin addiction.

To date, GAO's work in New York, California, Washington, Florida, and Texas indicates that most clinics have not been able to deal effectively with the drug problems of many of their patients. A high percentage of patients in methadone maintenance treatment for more than 6 months continued to use drugs. At the 15 clinics:

- Heroin and other opiate use ranged from 2 percent of patients at one clinic to 47 percent at another.
- The most commonly used other drug was cocaine which ranged from 0 to 40 percent. Clinic administrators told us that many patients also had a serious alcohol problem.
- Few comprehensive services were offered at the clinics, even though there was a high rate of unemployment among patients. Clinics usually referred patients to other agencies but did not know if patients used the referred services.

Recently, the Food and Drug Administration (FDA) has proposed an interim maintenance program. This program would allow methadone to be provided to addicts who are on waiting lists for comprehensive methadone treatment, but without the required counseling or rehabilitative services. The proposed program is intended to expedite treatment for the intravenous drug abusing population that is at high risk for contracting the lethal AIDS virus through needle use.

Based on GAO's preliminary findings from 15 methadone clinics, it is unclear as to how effective the interim maintenance program would be in reducing intravenous drug use and the spread of AIDS. Most of the clinics had patient populations that continued to show a high rate of drug use even after being in treatment for 6 months. The interim maintenance program provides fewer services than the clinics GAO reviewed, and GAO believes that additional information is needed before the program is allowed to be implemented nationwide.

Chairman Rangel and Members of the Committee:

Mr. Chairman, we are pleased to testify today on the preliminary results of our review of methadone maintenance treatment clinics, which we are conducting at your request. This request was prompted by your concern about whether methadone maintenance treatment reduces heroin and other opiate use among those treated, what services are provided during treatment, and how these programs deal with heroin addicts who are also using or addicted to other drugs.

BACKGROUND

Methadone is an orally administered, synthetic narcotic used in the treatment of an individual dependent upon heroin or other opiate drugs. Patients entering treatment in the mid-1960's, when methadone was first introduced, were usually addicted to a single drug--heroin. More recently, methadone clinics have been confronted with treating patients who abuse multiple drugs. At present, it is estimated that there are over 500,000 heroin addicts nationwide. Last year, about 100,000 persons were in methadone treatment.

Clinics providing methadone maintenance may be public clinics, private non-profit clinics, or private for-profit clinics. While states and the federal government fund methadone treatment, many

patients pay for a part or all of their treatment. The fee for treatment ranged from \$30 to \$420 per month at the clinics we visited.

Federal regulations require that methadone maintenance treatment combine the administration of the methadone drug with rehabilitative services to address the physical, psychological, and social problems of heroin addiction. A recent study indicates that methadone programs vary according to program characteristics, including the ratio of counselors to patients and the availability and quality of rehabilitative services.

Until recently, federal regulations governing methadone maintenance treatment defined the treatment goal as eventually getting the patient to a state of being free of all drugs, including methadone. This past April, the regulations were revised and no longer contain a definition of the goal for treatment.

Additionally, the Food and Drug Administration (FDA) has recently proposed an interim maintenance program. This program would allow methadone to be provided to addicts who are on waiting lists for comprehensive methadone treatment, but without the required counseling or rehabilitative services. The proposed program is intended to expedite treatment for the intravenous

drug abusing population that is at high risk for contracting the lethal AIDS virus through needle use.

RESULTS IN BRIEF

Although our review is not yet complete, we will discuss preliminary results based on 15 clinics we visited from March through June 1989 in New York, California, Washington, Florida, and Texas. These states are among those with the largest number of intravenous drug users in the country. The clinics provided services to over 3,300 patients, and most clinics served more than 200 patients. We plan to visit nine additional clinics during the next 2 months, with a report to be issued in early 1990.

Results of our work indicate that most clinics have not been able to deal effectively with the drug problems of many of their patients. A high percentage of patients in methadone maintenance treatment for more than 6 months continued to use drugs. At the 15 clinics we visited:

-- Heroin and other opiate use ranged from 2 percent of patients at one clinic to 47 percent at another.

-- The most commonly used other drug was cocaine. Clinic administrators told us that many patients also had a serious alcohol problem.

-- Few comprehensive services were offered at the clinics visited. Even though we noted high rates of unemployment for many of the patients, vocational and educational training were usually not provided by the clinics; instead patients were referred to outside providers. Clinics did not know whether the patients used the referred services.

HEROIN AND OTHER DRUG USE CONTINUED

AMONG PATIENTS IN METHADONE TREATMENT

Although methadone treatment is intended to curb the use of heroin, many patients continued to use heroin and other opiates. Use of these drugs by patients who were in treatment more than 6 months ranged from 2 to 47 percent. More than 70 percent of patients at the 15 clinics were in treatment for more than 6 months.

The clinics we visited in New York State had the lowest heroin use for patients in treatment more than 6 months, ranging from 2 to 5 percent. In general, the five California clinics showed the highest level of heroin use for such patients, ranging from 21 to 47 percent. While not all experts may agree, according to two

leading treatment experts, no more than 20 percent of patients in treatment more than 6 months should test positive for heroin use. We have not completed our analysis as to why these differences exist between the locations.

While addiction to heroin and other opiates is the reason patients seek methadone treatment, other drug use also seems to be a serious problem at most of the clinics. Cocaine was the non-opiate drug used most often by patients in the majority of the clinics. Cocaine use ranged from 0 to 40 percent for patients in treatment for longer than 6 months. Cocaine use was highest among patients in the four New York clinics we visited, ranging from 10 to 40 percent of the patients. Patients in California clinics for more than 6 months showed the lowest cocaine use, ranging from 0 to 8 percent. According to many clinic administrators, alcohol was also a serious problem; however, the clinics did not routinely test for alcohol use.

CLINICS PROVIDE FEW REQUIRED

REHABILITATIVE SERVICES

Federal guidelines no longer require that methadone treatment clinics have as a long-term goal that many patients will eventually become drug free. The 15 clinics we visited had different treatment goals. Five clinics sought to stop all drug use, including methadone; five clinics sought to stop all drug

except for methadone; while the other five clinics sought to stop heroin and other opiate use only. Most clinics were uncertain as to how they should deal with multiple drug abuse. The strategies for dealing with this problem varied among the clinics. The five clinics whose goal was to treat only heroin addiction disregarded a patient's use of other drugs. The other 10 clinics provided some counseling or threatened to remove patients from treatment if drug use continued.

Regardless of the clinic's goals, we found little difference among the 15 clinics in the types or scope of rehabilitative services provided to patients. While all the clinics provided counseling, only one provided on-site vocational and educational services.

Counseling, which may address issues such as drug abuse and self-esteem, is an important component of treatment. Though all the clinics provided counseling to patients, the potential benefits of counseling may not be realized at many clinics because of the heavy caseloads for counselors. At 10 of the 15 clinics, counselor caseloads were at least 40 and in some cases over 60 patients. Many counselors and clinic administrators noted the difficulty in providing more than minimal counseling to patients when a counselor's caseload exceeds 35 patients. Some clinic directors stated that counselor-patient ratios could not be

reduced because funds were not available to pay for additional counselors.

Equally important to achieving treatment goals are other rehabilitative services. Vocational and educational services would seem to be needed given the high rates of unemployment for patients at many of the clinics. According to FDA and the National Institute on Drug Abuse (NIDA), rehabilitative services are of key importance in the treatment of drug dependence. Federal regulations require methadone to be dispensed in conjunction with medical and rehabilitative services that will help the patient become a productive member of society.

The 14 clinics that did not offer vocational and educational services stated that they referred patients to other agencies for these services. Federal regulations state that services should normally be made available at the clinic, but the program sponsor is permitted to enter into a formal agreement with other agencies for these services. While the 14 clinics said they referred patients to other agencies for rehabilitative services, none had entered into a formal agreement with an outside provider. Moreover, most of these clinics did not receive feedback from referral agencies and did not know whether patients used the services.

MANY CLINIC OFFICIALS QUESTIONED THE
ADVISABILITY OF INTERIM MAINTENANCE TREATMENT

Finally, FDA, in collaboration with NIDA, has proposed regulations that allow interim methadone maintenance programs to be established. This program was developed in response to the AIDS epidemic among the intravenous drug abusing population and the concern with the limited availability of comprehensive methadone treatment. Most administrators for the 15 clinics we visited questioned the advisability of such a program.

According to a NIDA official, the proposed regulation is intended not as a treatment method, but as a staging program to reduce the spread of the HIV infection while addicts await admission into a comprehensive treatment program.

As proposed, patients who enter the interim maintenance program would be provided methadone without required rehabilitative services. However, patients would receive a physical examination and limited AIDS education. Also, no take-home medication would be allowed, nor would there be any requirements for periodic random drug screening or HIV testing.

Based on our preliminary findings from 15 methadone clinics, it is unclear as to how effective the interim maintenance program would be in reducing the spread of AIDS. Most of the clinics in

our review had patient populations that continued to show a high rate of drug use even after being in treatment for 6 months. Given that the interim maintenance program provides for fewer services than the clinics in our review, this raises concern as to how successful the program would be in reducing intravenous drug use.

Most of the clinic officials we interviewed did not support the concept of interim maintenance. One administrator stated that "interim maintenance treatment would not address the problem of addiction, it would only medicate the problem," since drug counseling would not be available. Concern has also been expressed that because the proposed interim maintenance program does not require either HIV testing or periodic random urine testing, there is no mechanism to determine its effectiveness in reducing the spread of HIV infection.

Most clinics we visited would not be eligible to have an interim maintenance program since they did not have waiting lists and treatment was available to anyone who sought it. Only four of the 15 clinics indicated that their treatment capacity was full and they were placing people on a waiting list. Two of these clinics were in New York, and the other two were in California. While one of the California clinics did not have any publicly funded treatment slots available, it would accept a person who had the ability to pay for treatment.

According to one methadone provider in New York City, based on a phone survey of clinics in the five boroughs during November 1988, 35 clinics responded that over 400 methadone treatment slots were available on that day.

OBSERVATIONS

In summary, our preliminary results have raised a number of concerns regarding the implementation of methadone maintenance treatment programs. These include:

- The substantial use of heroin by patients in many of the clinics we visited.
- The substantial use of other drugs, especially cocaine, by patients in treatment.
- The lack of priority given to rehabilitative services, particularly in view of the high unemployment rate we found among the patient population in some clinics.
- Based on our preliminary work, we believe that additional information is needed before interim maintenance programs are allowed to be implemented nationwide.

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We will address these concerns during the remainder of our work.

Mr. Chairman, this concludes my statement, and we will be pleased to respond to any questions you may have.