Evaluation of Specialist Methadone Services

Human Services

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Prepared by

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Health Outcomes International Pty Ltd

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This report reflects the period of the evaluation which commenced in February 1999 and concluded in June 1999.

Contents

Key Findings

The following is a summary of the key findings of the evaluation of Specialist Methadone Services (SMS) in Victoria. Additional information and explanations are provided in the body of the report.

- There is a general consensus that the SMS are providing high quality and valuable services to their target population. A holistic model of care and the use of case management techniques employing a multi-disciplinary approach are evident across all SMS. However, there are a number of systemic issues which are impacting on the effectiveness of SMS, and in particular on their capacity to refer clients to community-based service providers.

- The primary barrier facing Specialist Methadone Service provision (as proposed in tender specifications and program service plans) is the dearth of community-based prescribers (general practitioners) and dispensers (pharmacists) for clients using methadone. In particular, the lack of prescribing General Practitioners (GPs) and dispensing Pharmacists is identified as the major reason for 'bottlenecks' in the Specialist Methadone Service system.

- The supply of community resources (GPs and Pharmacists) in each region varies, although the consensus is that clients (and potential clients) in each region would be better served if more of these health professionals were involved in methadone maintenance treatment.

- The overriding pattern of service delivery shows a geocentric client distribution around SMS sites. There are many factors which may influence this 'geocentricity' around service sites, and detailed analysis of regional needs may assist in the explanation of this issue.

- Clients display a high level of satisfaction with the model of service delivery, intensity of services available and the staff employed by the SMS. The majority of clients involved in the consultative process had been involved in other methadone treatment programs in the past, and all clients reported the SMS as suiting them best.

- The 'weaknesses' of the services identified by clients related more to methadone itself, rather than the way in which services are provided. For example, the issues of daily pick-up and the side-effects of methadone were commonly reported as the main negative aspects of SMS treatment.

- Specialist Methadone Services are effectively serving a number of clients who may otherwise be unable to access methadone treatment services. This raises the possibility that there may be even more potential clients who are without services because of a lack of service places, geographic isolation, or a lack of awareness of SMS by the client or their clinician.

- Referring agents are generally satisfied with the model of service offered by the SMS, and the sector seems familiar with the rationale, eligibility requirements and general components of the services. Awareness of the existence, roles and eligibility criteria for referral to Specialist Methadone Services has improved over time.

- The level of secondary consultation and health practitioner training/education is less than should be expected, given the purposes for which funding is made available by Department of Human Services. The SMS tend to focus their energies and resources on direct client service provision more than secondary consultation, training and health professional support.

- There appears to be three groups of GPs with whom the Specialist Methadone Services come into contact:

  – Those with very high caseloads of methadone clients who use the SMS as a last resort or for secondary consultation only.

  - Those with quite small caseloads of methadone clients, who are reluctant to take on more, and who use the service when patients have a crisis or become more complex.

    and

  - Those who choose not to prescribe methadone whether they are accredited to do so or not.

- There is limited interaction between the SMS sites, and while they work within the same broad service provision framework, idiosyncratic practices exist in each region.
- The level of file maintenance, treatment plan completion and format of ITPs shows significant variation between individual clinicians and between service sites, and there is considerable scope for greater standardisation of documentation between the SMS. There is no standard referral mechanism, ITP format or review process across the four SMS.
- The evaluation of the services against performance indicators is problematic. Some indicators are problematic from the perspective of the SMS (such as completion of withdrawal), some are measured differently by each service, and the quality and reliability of other data elements (such as ITP completion and review) varies.
- Specialist Methadone Services are reluctant to report against the withdrawal indicator, due to a perception that it is an inappropriate performance measure. This is despite the fact that withdrawal targets are part of agreed Program Service Plans.
- The Specialist Methadone Services tend not to strictly enforce regional boundary 'catchment areas' for clients. Many instances of clients travelling significant distances in order to continue treatment at a Specialist Methadone Service were noted.
- The Specialist Methadone Services often act as a 'service of last resort', particularly when treatment has been ceased abruptly in the community.
- Relationships between the services and their corresponding Divisions of General Practice, and formal links with GPs in the service region are variable.
- Shared care arrangements have successfully been adopted in some circumstances, benefiting both the client and their community-based GP or pharmacist.
- The Specialist Methadone Service model is unique, as it enables an holistic approach to methadone maintenance treatment, by incorporating medical, counselling, and case management services in order to stabilise clients for a return to less intensive community-based treatment.
- GPs cannot match the intensity of input provided by the Specialist Methadone Services within current Medicare funding arrangements. That is, until GP reimbursements (currently via Medicare payments) recognise the level of input required to serve the client group (counselling and case management time, for example), low levels of GP involvement in methadone maintenance treatment are likely to remain.

Introduction

The first of the Specialist Methadone Services (SMS) in Victoria was established in 1994 as part of a redevelopment of drug treatment services, during which resources for institutional based services were redistributed to increase the range of community-based services.

While general medical practitioners (GPs) provide the majority of methadone treatment services in Victoria, SMS were developed to provide support for those people receiving methadone treatment with complex medical, psychiatric or psychosocial problems. It was envisaged that the SMS would operate in association with a general teaching hospital, and would operate with the following service objectives:

- To provide specialist assessment and treatment services to methadone clients with significant medical, psychiatric and/or psychosocial problems.
- To provide consultancy services for health practitioners involved in providing community and hospital-based methadone and other opioid pharmacotherapy.
- To participate in the training of health practitioners involved in providing methadone services (including medical practitioners, pharmacists, nurses and counsellors.)

The provision of counselling services to people on methadone was recognised as an important role of the SMS, in order to improve the effectiveness of care for those with complex needs. The proposed model of integration of community resources and SMS for methadone clients is described in Table 1 below.

Table 1: Integrating Community and Specialist Methadone Services

Stage of Treatment	Component of Treatment			
	Case Management	Counselling	Dispensing	Medical Services
Prior to Referral	GP	GP	Community Pharmacy	GP
Following Intake	SMS	SMS	SMS	SMS
Following Early Stabilisation	SMS	SMS	Community Pharmacy	SMS
Ongoing Stability	GP	SMS	Community Pharmacy	GP
Return to Community	GP	GP	Community Pharmacy	GP

(Source: Tendering Guidelines, Tender Number 151, 30.9.94.)

Since 1994, four Specialist Methadone Services have been established in metropolitan Melbourne. The commencement of operation of each SMS was gradual, with the final service established in July 1997. As part of a continuous evaluation program, the Department of Human Services called for tenders to conduct a process evaluation of the four SMS and appointed an external consultant to undertake the study.

This report presents the findings of a process evaluation of the four SMS, conducted by Health Outcomes International Pty Ltd. In the course of the evaluation, consultations were undertaken with a wide range of stakeholders, whose input has contributed significantly to the review. The cooperation and support of all parties participating in the review is gratefully acknowledged.

Terms of Reference

The evaluation of Specialist Methadone Services had the following terms of reference:

Project Objectives

To assess Specialist Methadone Services (SMS) in respect to:

- Their strengths and weaknesses.
- The extent to which they are operating within the general and specific key service requirements and conditions of tender.
- The extent to which they are meeting their performance measures and targets (as outlined in their Agreement with the Department of Human Services).
- To identify successful innovations in the services or deficits in the treatment model.
- To identify systemic issues which impact on the successful delivery of the service.

Project Outcomes

The outcome of the project was to be a comprehensive report, in publishable format, documenting the achievement of the project outcomes.

Project Specifications

This project required the consultant to:

- Ensure appropriate participation and consultation with the service target group, their families/significant others, relevant agencies, government departments, community groups and those identified as stakeholders.
- Report regularly to a Reference Group, established to monitor the progress of the project.
- Frame the investigation and prepare the report in the context of a harm minimisation approach and consistent with Department of Human Services policy.
- Highlight relevant national and international comparisons.
- Provide a thorough analysis and fully substantiated findings, in publishable format, that may be used by the drug treatment service sector and the Department of Human Services for program and policy development.

Project Methodology

Stage 1: Project Initiation and Planning

This stage confirmed the process, direction, timing and scope for the project, together with reporting lines, and scheduled meetings with the Review Reference Group. Arrangements were also made to obtain relevant documentation and data from the Services and the Department to support the review (see Stage 3 below). This stage also identified an initial list of the key stakeholder groups and individuals to be consulted. These issues are discussed below.

Stage 2: Literature Review

This stage involved an international literature review to identify relevant national and international benchmarks for Methadone Maintenance Treatment (MMT) services as a comparison to the processes and outcomes exhibited in the Victorian SMS.

The purpose of the literature review was to learn from international experience whether there is a proven body of evidence which may be used to inform the project, promote development in specific areas, and encourage debate among stakeholders on issues of interest. Particular emphasis was placed on the specialised nature of the Victorian SMS, with an attempt to determine best practice principles for such comparable services.

The results of the literature review are presented in Section 4.

Stage 3: Activity Data Collection

In this stage, qualitative and quantitative data from service providers and the Department of Human Services were collected. Examples of the information sought include relevant policy and procedure manuals/documents that describe the arrangements made for the provision of services provided, the nature of the relationships between different service providers, and the range and quantum of services provided. The key service requirements for each of the contracted services provided the initial basis for defining the range of data elements and measures collected in this stage (as defined in Program Service Plans and Tender Specifications). In addition, information gathered from the literature review was applied where similar service comparisons could be made, with this information highlighting the specialised nature of the SMS. Some of these data were collected using questionnaires designed by our team specific to each service, as part of the initial consultative phase.

Data were collected individually from each of the four SMS, and are presented collectively in Section 5.

Stage 4: Consultations with Stakeholders

This stage entailed consultations with key stakeholders with an interest in each of the services under review. The consultations were undertaken using a combination of focus groups and face-to-face interviews, or where this was not possible, via telephone. The interviews were of a semi-structured nature, addressing specific issues as required in the Terms of Reference for the review, as well as providing stakeholders the opportunity to expand on or contribute their views on issues of immediate relevance to the review. Importantly, client consultations were also conducted at each service site.

The objectives of the consultations were primarily to inform the qualitative aspects of the evaluation, with particular regard to:

- Satisfaction by different stakeholders on the quality and range of services provided.
- The approach to and effectiveness of case management.
- Perceptions of the nature and strength of linkages between the various service providers and the continuity of care.
- Views on access to services.
- Perceptions of the mechanisms for training and consultancy services for health practitioners.
- The adequacy of services provided to carers and families.

These issues formed the basis of the interview structure.

The consultations were conducted at a regional level, focusing on the individual SMS. Consultations were conducted with the following stakeholders:

- The Department of Human Services (Drug Treatment Services Unit, including regional offices).
- Drugs and Poisons Unit.
- Staff of the Specialist Methadone Services.
- Other allied service providers, including:
  - Chemical Dependency Unit, Royal Women's Hospital
  - Westernport Drug and Alcohol Service
  - Odyssey House
  - Moreland Hall
  - De Paul House
  - Windana Society.
- Individual General Practitioners.
- Divisions of General Practice.
- Consumers and their families.

These consultations continued throughout the course of the assignment, to provide stakeholders the opportunity to comment on and contribute to the findings of the review. Several stakeholders were contacted on several occasions in order to ensure all appropriate information was collected, and that this information was correctly interpreted. Particular care was taken to ensure the anonymity of consumers and their families, and to protect their privacy.

A synthesis of the information obtained throughout the consultation process is presented in section 5.

Stage 5: Report Production

This stage comprised the preparation of a Draft Report, which drew together the information gathered in each of the preceding stages. Particular attention was paid to the Terms of Reference for the project, and with guidance from the project Steering Committee, was further refined and presented as this final report.

Literature Review

Introduction

The abstracts of approximately 250 articles were reviewed following a request to the dedicated retrievals centre of the State Library of South Australia, Bizline, using the keywords 'methadone treatment'. Of these abstracts, the full article was extracted for approximately 30. In addition, the National Drug and Alcohol Research Centre was consulted during the preparation of the literature review in order to refine the search.

It is widely accepted in numerous countries that methadone treatment is effective in reducing the intake of opiates, minimising social dysfunction and reduces the risk of infection with blood borne viruses including HIV, Hepatitis B and C (Ward et al, 1992; Bell et al, 1994). Numerous models of methadone treatment exist, and a dramatic increase in demand for methadone treatment in general practice has occurred since the inception of treatment services in 1970, and significant expansion in Australia from 1985 (Ward et al, 1994). This increase in demand generates a concomitant increase in workload in general practice as recognised by Wilson et al (1994). It may therefore be implied that assistance with the management and stabilisation of complex patients requiring methadone treatment may better equip GPs to establish effective clinical relationships with these patients.

Service Models and Best Practice

By their very nature, it may be argued that the entire client group involved with methadone treatment services is complex, and that methadone maintenance even in its simplest form is a 'specialist' service.

While there is a large body of literature regarding 'generic' methadone treatment models, there is a dearth of information regarding 'specialist' methadone services. There have been proposed, however, models of care which recommend an 'intensive stabilisation phase' (by Moolchan and Hoffman (1994), for example). This phase of treatment identifies objectives, such as; stabilising the patient on an optimum dosage of methadone; addressing acute medical problems; minimising the use of other drugs; developing an initial treatment plan; establishing counselling relationships; conducting needs assessment; and encouraging others to become involved in the recovery process.

Current methadone treatment models range from methadone provision with little other therapeutic input (and expected abstinence from heroin), to intensive counselling and psychotherapy input in addition to methadone provision. Combinations of these models, depending on participant need or streaming on the basis of graduating between phases of treatment, have also been initiated (White et al, 1996). These different models may be applied depending on the concept of treatment that is being followed. For example, the medical model of methadone treatment assumes opioid dependence as a metabolic disease, while the non-medical model views opioid dependence as a behavioural disorder that may be psychogenic, conditioned, or a form of criminal activity (Ward et al, 1992). The goal of the medical model is successful maintenance on methadone, while the goal of the non-medical model is a drug-free life for the participant.

Performance indicators for methadone maintenance program processes may be broadly allocated into the following groups:

- Assessment
- Methadone dosage
- Monitoring
- Counselling and psychotherapy
- Duration of maintenance
- Post treatment options (Ward et al, 1992).

Components of Treatment

Referral and admission procedures are recognised as vital to the retention of clients in methadone treatment services (DeMaria and Weinstein, 1995; White et al, 1996). Langrod (in Bell et al, 1994) suggests that 'the admission process is probably the most important phase of methadone treatment'. The formality and duration of referral and admission processes have an impact on retention rates in methadone treatment programs, with Bell et al (1994) noting that prolonged, formal admission and assessment deters some applicants and does not necessarily improve in-treatment performance. Maddux et al (1995) support this assertion by stating that pre-treatment attrition can be markedly reduced by prompt admission and medication.

When deciding whether to refer patients to methadone treatment programs, DeMaria and Weinstein (1995) suggest that consideration be given to patient's age, length and severity of drug use, previous treatment history and constraints to treatment. In general, those with a long history of abuse seem best suited to methadone treatment. Admission and eligibility criteria including age at least 18 years, current physiological dependence on narcotics and a history of use of at least one year are used in the United States (US Federal Register 1989).

Ward et al (1994) and Saunders (Ed) (1994) state that higher dosage levels, that is, greater than 50 mg, are more effective than lower doses in maintenance programs. DeMaria and Weinstein (1995) suggest that a daily dose of 60–100 mg optimally prevents withdrawal and reduces opiate craving and use. White et al (1996) note that higher dosage levels also have a positive influence on retention rates. In addition, involving the participants in decisions relating to dosage levels is seen as important from participant satisfaction, opiate use and patient retention perspectives (White et al, 1996).

The rationale for monitoring participants using urinalysis (or other methods, such as sweat patches) is to ensure that the dispensed methadone is being ingested and to monitor other drug use (including alcohol). Baker et al (1995) state that monitoring as a deterrent to relapse is yet to be adequately demonstrated. Magura (in Baker et al, 1995) states that self-reporting of use of opiates is as effective as urinalysis for those in methadone treatment programs. Also of interest is the finding that unannounced urinalysis tests did not necessarily detect more violations (Baker et al, 1995).

The provision of supplementary/ancillary services offering psychosocial support is regarded by many as essential for effective methadone treatment (Kraft et al, 1997; Ward et al, 1994). Therefore, it may be considered best practice to include the assessment of need for these services in specialist methadone service provision. There is some debate regarding the role of these ancillary services, however, primarily due to economic considerations and the availability of other services (Ward et al, 1992). For example, definitive cost-benefit analyses have not demonstrated the return on investment in these services, particularly where mainstream providers (such as community health services) may be accessible. The capacity of GPs to provide these additional non-medical services, such as counselling, is limited, however, as these activities are not funded by the Medicare system.

The Australian average duration of treatment for participants in methadone treatment programs is difficult to gauge, although Ward et al (1992) suggest that an average duration of methadone treatment in Australia is approximately 15 months. Figures vary greatly between and within programs (Wilson et al, 1994), and the importance of individually tailored services, taking into account dosage, duration of treatment and level of intervention as independent variables, is highlighted (Ward et al, 1992). This supports the assumption that there is no single 'correct' treatment plan.

Most people who leave methadone maintenance programs do so in the hope of leading an opiate-free existence. They are also generally apprehensive about their prospects of success (Ward et al, 1992). There is little literature dealing with the interaction between methadone treatment services and other sectors (mental health and social welfare, for example), although Toumburou (1994) recognises that there is good evidence for recommending the inclusion of the family, and other community sectors, in illicit drug treatment. The Department of Human Services' view is that some SMS clients will move off methadone over time and it is to this that the withdrawal performance measure refers.

Other Considerations

Performance Indicators for Specialist Services

The widely acknowledged positive impact of methadone treatment on HIV and other infections (particularly Hepatitis B and C) may be considered a viable performance indicator, although some treatment programs may not have identified this measure in service objectives. Performance measures for the provision of specialist methadone services (as designed in Victoria) are quite different from those that may be applied in 'mainstream' methadone treatment settings. For example, the stabilisation goal of the specialist methadone services differs from the withdrawal goal of most GP based programs.

Public Versus Private Methadone Programs

There are significant differences in service provision model, effectiveness and admission protocols between publicly and privately administered programs. Historically, there has been conflict between the two (Caplehorn, 1992). In extreme examples of this conflict, accusations have been made by public providers that private practitioners have contributed to increases in opioid abuse (Bewley and Ghodse, 1983 in Caplehorn, 1992). Caplehorn's (1992) findings indicated that while there were differences between the patients in each type of service, there was no evidence to suggest that unsuitable individuals were being admitted into maintenance.

Community-Based Service Provision

Current Victorian government policy promotes the provision of drug and alcohol treatment services in a community setting wherever possible, rather than in institutions or large clinics. This implies that the responsibility for methadone prescription and supply lies primarily with community general practitioners (GPs) and pharmacists. The willingness of GPs and community pharmacists to participate in methadone treatment services, and their confidence in managing these clients, is vital in ensuring needs are met and that continuity of care is assured.

There has been some reluctance by GPs to become involved in methadone treatment services, with a study by Turning Point (1998) noting some of the reasons for this reluctance. These reasons included: potential loss of existing clients; increased risk of crime; increase in workload; and financial concerns.

Conclusion

The literature suggests that there are some criteria by which methadone programs may be evaluated, although broadly accepted best practice indicators suited to SMS have not been found. This reflects the fact that SMS are part of a continuum of service provision, with the end point of their involvement often being referral of the patient to other community-based providers. There is, however, some recognition that specialist services (or components of service) may be useful in the treatment of patients with 'complex needs' (for example, Moolchan and Hoffman 1994).

Generic methadone treatment program protocols may be useful as a baseline by which to undertake a process evaluation, although the intricacies of the SMS model may require review based on provider, stakeholder, government and consumer feedback. The identification of specific 'Specialist Methadone Services' is unique, and may be considered as part of a drug and alcohol treatment service 'continuum', with components that may be difficult to evaluate in isolation from other components.

Summary of General Findings

While there is one general model of service to which the four SMS are required to conform, there is a level of idiosyncratic operation which exists between the service sites. These are highlighted in the findings for the individual services presented in Appendices A to D.

There are, however, several findings and recommendations that may be applied to the service concept as a single entity, and to the SMS service model.

Strengths and Weaknesses of the Specialist Methadone Services

Strengths

The consensus from a wide range of stakeholders is that the SMS are generally operating effectively within the limitations imposed by the current level of resources allocated to them and the difficulties associated with discharge from the service. (This is discussed further in Section 5.1.2 below.) There was appreciation of the fact that generally the SMS readily accept new referrals with minimal waiting times for acceptance into treatment. There was also a general consensus from all stakeholders consulted that the model of treatment was appropriate. Most stakeholders consulted considered that the SMS are used as a referral destination for clients in crisis, when community GPs are no longer able to adequately provide treatment, and as a 'service of last resort' when no other treatment options were available to clients.

The majority of community-based treatment providers felt that the SMS were adequately promoted and marketed, although the specific eligibility criteria for admission were not completely understood by all. Many of the GPs and Divisions of General Practice consulted appreciated the 'safety net' role provided by the SMS, that is, the support of being able to either refer complex patients to the SMS, or to seek clinical advice from SMS staff regarding appropriate treatment for their patients. While this back-up function was appreciated, it is not used consistently by GPs.

Among consumers consulted, there was strong support for the SMS model of care and the services they provide. While many of them utilised (and valued) the counselling and other support services offered by the SMS, others chose not to use them, preferring to restrict their contact with the service to the prescribing/dispensing functions. The flexibility of services offered was identified as of great importance to clients, who generally noted that SMS services were available to them when few other treatment options were available. There was also recognition that services are tailored to meet the individual needs of clients. All acknowledged that they were actively engaged in developing their treatment plans and setting goals. The 'one-stop-shop' model of services, in which the SMS offers medical, counselling, pharmacy and case management services under one roof tends to simplify access to services by clients.

While the 'one stop shop' model is a clear and simple way of accessing services, some clients were also engaged in shared care arrangements between the SMS and a community provider, usually a community pharmacist. This significantly improves access for clients, particularly for those who live some distance from the SMS site. Given the daily pick-up regime required with methadone treatment, negotiation of local pharmacy dispensing makes a significant difference to ease of access for clients.

From information obtained during the consultation process, and in the review of records and treatment plans, it was demonstrated that the SMS have adopted a holistic approach to case management. Through this approach, clients were not treated only for their drug-related health concerns, but psycho-social issues were also addressed, including employment, education and relationship considerations. Many of the clients consulted valued this aspect of service highly.

Weaknesses

The major limitation of the SMS has been their capacity to refer patients back to community-based providers. The goal underpinning Specialist Methadone Services has been to support the existing community-based system of General Practitioners (GPs), pharmacists and mainstream drug and alcohol services. In this sense, SMS may be seen as part of a drug and alcohol service continuum. The overwhelming consensus of responses throughout the sector and within the SMS identified the lack of sufficient community prescribers and dispensers as the greatest barrier to providing specialist methadone services in the manner intended.

In particular, the lack of adequate GP and pharmacy resources involved in methadone treatment regimes was identified as causing a 'bottleneck' in the SMS. That is, while the intake and stabilisation process is relatively smooth, there is often extreme difficulty in referring the 'stabilised' client back into community methadone programs. The Drugs and Poisons Unit identifies 134 methadone prescribers in the Melbourne metropolitan area, although, according to information from the Direct Line service, only about 12–20 per cent of this number are currently willing to accept new clients into methadone maintenance treatment.

This systemic flaw has been identified universally across all regions, and even by clients themselves. Community GPs and pharmacists, as well as other community-based drug and alcohol treatment services have identified the 'bottleneck' problem within the SMS, and generally recognise that the lack of community prescribers and dispensers contributes to this. A number of explanations of the lack of adequate referral/discharge options have been proposed by service providers, including:

- Insufficient numbers of trained community-based general practitioners.
- GPs' and pharmacists' concern regarding the impact participating in methadone treatment may have on existing patients.
- GPs and pharmacists are concerned about the risks associated with accepting this client group, such as theft, abuse, etcetera.
- There is a perception that the increased workload which comes with working with these clients is not sufficiently remunerated.
- There is a perception that a willingness to accept some methadone clients will result in a massive demand for service by other potential methadone clients.
- The risk of overdose or client death is considered significant and unacceptable to some GPs.

The time at which referral is made by a GP to the SMS is also important. It is recognised that GPs often refer a patient to the SMS after the patient is in crisis, or requires more input than the GP can offer. By this time, the GP is willing to refer the patient, but is often reluctant to accept referrals back from the SMS.

Some drug treatment providers, particularly regionally focused services or those some distance from the SMS site, indicated a reluctance to refer clients to the SMS if they knew that travel arrangements would be difficult for the client. Similarly, there was a reluctance to refer clients when the provider was aware that the SMS was 'full' or operating at capacity.

At the same time, the data on client utilisation of SMS services shows a high degree of concentration of clients or geocentricity, that is, the large majority of SMS clients reside within five kilometres of the SMS site. This raises the question of equality of access to services across their respective regions, and the extent to which the SMS are providing a region-wide service. Opportunities exist to develop outreach services to more distant parts of the regions. However, such an approach may call for additional funding, as well as requiring more community prescribers and dispensers to be provided, in order to avoid exacerbating the 'bottleneck' problem previously described.

Some community providers are involved in 'shared care' arrangements with SMS, and generally expressed satisfaction with these arrangements. In some instances, however, the SMS may not always be the most appropriate service for the client, but in the absence of other appropriate supports (particularly prescribing GPs), SMS are engaged as the service of last resort. This 'back up' role has been important to many GPs and other treatment agencies. However, by providing services to patients who may not necessarily fit the SMS criteria, other prospective clients in greater need may be missing out on the appropriate level of service which only the SMS can provide.

Another limitation of the SMS model is that of documentation. The documentation related to referral, treatment planning, goal setting and review varies greatly within and between the SMS. While the impact this has on client outcomes cannot be clearly demonstrated, it presents significant difficulties when attempting to compare the activities and approaches of different sites, monitoring service performance and in ensuring continuity of care. Similarly, the information relating to service activity (collected either by the agency or the ADIS) does not demonstrate a high level of consistency between and within each SMS. Issues of consistency and documentation are discussed further below.

The initial model of SMS treatment proposed a dual focus on direct client service provision, and an element of education, training and secondary consultation for health professionals involved in methadone maintenance treatment. The current demand for SMS client-based services has meant that the SMS have chosen to focus almost entirely on direct service provision, thus leaving minimal resources available to be applied to these non-client activities. This may be considered as a breach of the terms of funding and service agreements between the SMS and the Department of Human Services, by which funds are made available. In some instances, additional resources have been requested and made available for the purposes of non-client-based service, such as secondary consultation, professional education and training.

Recommendations

- New strategies to make methadone treatment more appealing to community practitioners (including GPs and pharmacists) should be considered. For example, offering more structured support services (such as client counselling and support) may reduce workloads for individual GPs. Collaborative partnerships between elements of the service system should be explored.
- Divisions of General Practice, Royal Australian College of General Practitioners, Pharmacist's Guild or other professional/peak bodies should be engaged in strategies to increase participation in methadone treatment.
- Training and education of GPs should include the promotion of early intervention techniques, whereby referral is made to the SMS prior to crisis or emergency and before the client's relationship with the GP is adversely affected.
- Community-based drug treatment providers would benefit from being involved in any education or training activities, in addition to GPs and pharmacists, and should be included as appropriate.
- Opportunities for the development of SMS outreach services to more distant parts of the regions should be investigated and developed, in order to improve equality of access to SMS. The impact of this approach on SMS funding requirements needs to be considered.
- Formal eligibility criteria and referral procedures should be developed. Agencies with a referring relationship with the SMS should be involved in the development of these protocols, become familiar with their content and adopt their use.

- Where innovative practices are implemented by a SMS, community providers should be made aware of them. Information regarding potential waiting times for admission to SMS treatment should also be made available to referrers. Regional forums or structured information sharing mechanisms (for example, newsletters) may facilitate this information flow.
- Consistent information management and documentation strategies should be developed.
- Extent to Which Services are Operating Within Key Service Requirements and Conditions of Tender.
- The Key Service Requirements specific to SMS according to Tendering Guidelines are:
- To provide assessment, referral and specialist consulting services..
- To provide case management, including:
- Assessment of client's needs.
- Negotiation of an individual treatment plan with the client.
- Appropriate integration with community methadone services.
- Discharge planning.
- Case monitoring.
- To work with a pharmacist skilled in treating those with problems of injecting drug use.
- To provide pathology services.
- To facilitate client access to other services appropriate to their health and welfare needs.
- To provide advice and clinical opinion to general practitioners prescribing methadone concerning clients with complex needs.
- To provide training and a consultancy service for health practitioners, including pharmacists and counsellors providing methadone services.
- To provide appropriate services, where relevant, for carers and families of those affected by drug use.

Overall Assessment Against Key Service Requirements

In general, the SMS are operating in a manner which addresses all requirements listed above to varying degrees.

The performance indicators applied to the four SMS contain many similar components. However, there is a degree of variation between the requirements of each of the services. It is understood that this variation exists due to the negotiation of Funding and Service Agreements at a regional level.

Consultations with SMS staff, clients and allied service provider agencies revealed that intensive case management is offered to a significant number of clients. Client interviews reflected a consensus that the 'one stop shop' for treatment, incorporating medical appointments, counselling and dispensing, simplified the service system and gave the client flexible treatment options. Clients, however, noted that attending the SMS daily simply to pick up methadone doses was both cumbersome and onerous at times, but they recognised that a lack of adequate pharmacy support in the community contributed to the requirement to do so.

The treatment plan/file audit demonstrated that, although documentation varies in both detail and format between each SMS, case management services, including assessment, monitoring and planning, were provided to clients. The quantity or intensity of case management offered to clients also varied, primarily due to workload constraints, but also in response to client wishes and empowerment. Case management generally included individual treatment planning, goal setting and monitoring, and it was demonstrated that where appropriate, referrals to mainstream health, welfare and treatment services were made.

All SMS have links with an on-site pharmacy service, and conduct urinalysis testing for clients regularly. Where appropriate, linkages with other services are also fostered, with shared care arrangements implemented on some occasions. While staffing structures vary between the SMS, all have medical personnel (either GPs or psychiatrists) and qualified counselling staff (usually social workers or psychologists).

The requirements relating to training, consultancy and back-up advice for community methadone clinicians were identified as the most difficult for the SMS to meet within current funding levels. This is primarily due to the workload associated with ongoing case management and the support of large numbers of clients, and in identifying community-based services as referral destinations. In some instances, additional funding has been allocated to SMS to enhance their education, training and secondary consultation roles.

It is uncommon for dedicated services to be provided to carers or families, although case management and treatment planning usually incorporates a range of issues affecting the client, including relationships, family and legal issues, such as guardianship.

Recommendations

- SMS should ensure that a balance is achieved between direct client service provision, and the other elements of their service objectives, namely secondary consultation, education and training. This may include review of the way in which available resources are distributed.
- The Department of Human Services should undertake an analysis of the time required for direct client work, secondary consultation and training with a view to establishing targets/benchmarks as appropriate.
- Shared care arrangements should be promoted where possible, particularly with community GPs and pharmacists, in order to promote continuity of existing client–clinician relationships.
- The empowerment of clients should be encouraged, so that they are given as much control as possible in their treatment regime.
- Greater standardisation of documentation of case management strategies is required both within and between the four SMS, to ensure a similar level of client care, regardless of individual clinician or the region in which a client resides.

Extent to Which Services Are Meeting Performance Targets

Performance targets for each SMS are identified in the Program Service Plans (PSPs) negotiated with regional offices of the Department of Human Services.

Appropriateness of Performance Targets

Some SMS staff have questioned the appropriateness of some components of the PSP, particularly the requirement that certain proportions of clients complete 'withdrawal' while participating in an SMS program. There is widespread understanding that the SMS have a stabilisation role, whereby clients with complex needs are referred by community clinicians, with the aim of receiving intensive support, ultimately enabling the client to return to their previous community-based provider. Interestingly, each SMS has a different 'withdrawal' target, and the variation is quite significant. In this model, 'withdrawal' appears an inappropriate measure of performance for the SMS, as the requirement of specified proportions of clients achieving some short-term goals identified in their Individual Treatment Plan (ITP) is included in each PSP already. SMS seem reluctant to collect information regarding the withdrawal performance indicator, although it is part of their current service agreement obligations. The absence of reporting on withdrawal may reflect the belief of SMS that their role is not to achieve withdrawal. This may in turn influence the motivation of SMS to assist clients to 'move beyond' methadone maintenance.

The concept of an 'episode of care' has also been the subject of some discussion. While there is little opposition to, or misunderstanding of, the use of such a measure, clinicians have had to adjust to the concept. The scope for interpretation at the individual clinician level is appreciated by most, and each SMS reported having little trouble meeting their episode of care quota as specified in their PSP. Clients generally reported that they were satisfied with their involvement in treatment planning and goal setting, which form the framework for an episode of care.

Among the key performance indicators is the requirement to monitor the extent to which clients are achieving short-term goals as set out in their ITPs. An examination of the data and recording systems in each of the SMS shows a lack of consistent (if any) reporting against this criterion. While the monitoring of goal achievement may be undertaken as part of their ongoing case management, the absence of supporting documentation makes it difficult to evaluate this activity. To the extent that the documentation of outcomes achieved is an integral part of case management and continuity, this is an area that requires attention and improvement by all SMS.

The monitoring of client satisfaction was, until recently, the sole responsibility of the service provider. The Client User Survey implemented by the Department of Human Services should now enable the collection of consistent client satisfaction data across all drug and alcohol services. Until then, client satisfaction was measured in an ad hoc fashion, with variable sample sizes and survey components. Individual providers are still able to maintain their own client satisfaction data, as it is likely to assist them in ongoing quality assurance strategies.

The measurement of training and secondary consult functions of the SMS were also recognised as difficult, for reasons highlighted in Sections 5.1 and 5.2.

For the 1998–99 financial year, some performance targets have been altered slightly to include new measures. The remaining performance indicators, such as timeliness of assessment; client satisfaction; treatment plan development and review; and gender balance within services, were all considered appropriate for SMS.

Recommendations

- The requirement for clients to complete 'withdrawal' as a performance measure should be reviewed, and a more appropriate measure of outcome developed. However, the lack of appropriate reporting against this performance indicator by SMS should be addressed.
- Clinical staff in each SMS should be clear on what may constitute an episode of care. Where appropriate, training for these staff should be made available. This would ensure a consistent understanding of the concept between SMS.
- Documentation on ITPs and the achievement of goals requires improvement across all SMS, and should be standardised to a greater extent.
- While regional needs may require variation in performance measures between each SMS, consistency should be promoted where possible. For example, waiting time benchmarks may be applied to each service site, with inability to meet these targets indicating a need to review work practices or resource allocation to the regions.

Successful Innovations and Deficits in the Treatment Model

In general, the SMS have a limited capacity to offer services in excess of those prescribed in their service agreements. In fact, the education and secondary consultation functions outlined in the service agreements of the SMS have been additionally funded, on occasion, in recognition of this. It was generally agreed by operators of each SMS that services cannot completely fulfil service plan obligations without exceeding allocated budgets or compromising the intensity (or quality) of client care.

Notwithstanding these limitations, some innovative practices and protocols have been established by the SMS. These include shared care arrangements with GPs or other community providers, such as the Chemical Dependency Unit of the Royal Women's Hospital. The configuration of each SMS also affords flexibility and multi-disciplinary approaches to service provision. Each SMS has an on-site pharmacy which dispenses methadone to clients, although individual arrangements between clients and community pharmacists are made where possible.

The SMS have generally adopted similar staffing structures, and tend to operate by employing similar processes and procedures. There is, however, a degree of idiosyncratic activity between the SMS, particularly in regard to the extent and format of their documentation.

Recommendations

- Specialist Methadone Services should explore collaborative projects to meet particular service needs at a broad level, such as education and promotion strategies.
- Collaborative service development projects should also be encouraged to meet regional needs, particularly for recruitment of additional community GPs and Pharmacists.
- Shared care arrangements between the SMS and other community-based treatment providers should be explored and encouraged, particularly when only specific components of care cannot (or will not) be provided by existing community services. For example, where a client's medical, prescription and/or dispensing needs are being adequately met by their local GP or pharmacist, yet intensive counselling and support is required, the SMS may be utilised for these specialised services only.

Systemic Issues Which Affect Successful Service Delivery

The broad systemic issue of gaps in the community-based methadone program has been raised earlier in this report. The systems of operation of each SMS also impact on how effectively services are provided.

There are variations between the SMS regarding formal administrative processes, such as referral mechanisms, file maintenance (including treatment plan documentation) and discharge mechanisms. For some referring agents, this variation has proved confusing, although it was not identified as inhibiting service quality to any great extent.

In many instances, it appears that documentation processes and formats are in place, although compliance with these varies. Each SMS operates within individual guidelines, identified in the Policy and Procedure manuals each service has developed. In addition, each SMS has developed individual pro formas for case note documentation, with limited 'sharing' between service sites. The content and detail of information presented in these formats also differs between the SMS. For example, file and treatment plan audits revealed variable levels of documentation regarding treatment planning and review, goal setting, assessment and correspondence. Case file notes demonstrated that planning, goal setting and reviews were occurring as a matter of course in most instances, although explicit documentation of these processes was not evident on a number of occasions.

As previously noted, the geographic distribution of service provision shows a high degree of concentration of clients or geocentricity around the SMS service sites. Some clients also reported that it was difficult to arrange transport to service sites, particular when using public transport. A number of explanations have been put forward to explain the client distribution. The most likely of these is that local clients and providers are most aware of the service and its function, whereas potential clients (and clinicians assisting them) some distance from the service site may be unaware of, or unwilling to use, the SMS because it is geographically difficult to access. This reinforces the previous recommendation that the feasibility of outreach programs should be explored, or collaborative models of care developed which engage more community-based providers in the delivery of methadone services.

Recommendation

- Standardised mechanisms for referral, treatment planning, review and assessment should be developed and implemented consistently between SMS. Additionally, these processes should be documented consistently in an agreed format.

Other Findings

Some staff of the SMS expressed concern about the restricted nature of the SMS model. Because the chemical used in the intervention, rather than the service aim, defines the treatment, this limits the client group to those receiving methadone only. With the recent commencement of various alternative pharmacotherapy programs, such as naltrexone, LAAM and others, it has been suggested that clients involved in these regimes may also benefit from the intensive support services provided by SMS.

There is a perception that the demand for service is underestimated, as referral numbers rely heavily on the community services from which they are generated. Given the consensus of opinion that there is a significant shortfall in community methadone providers, and subsequent unmet need, this is likely to translate into a demand for Specialist Methadone Services which cannot be fully met. The DIRECT Line information and referral service attempts to place prospective methadone treatment clients with appropriate community providers, although this is not always possible. Privacy and confidentiality issues prevent the maintenance of an accurate 'waiting list' for methadone treatment by this service, although unmet need is certainly recognised.

There is a significant demand for SMS input (either for assessment only or ongoing treatment) into the management of clients for whom pain management is a primary concern. The demand for this input is quite high, and SMS have had occasion to place quotas on the amount of resources that can be applied to this group.

Charging policies and arrangements for dispensing vary between the four services, although they generally offer methadone dispensing at a lower cost than community pharmacies. Some clients see the charges of some community pharmacies as a deterrent, and these pharmacies vary in the way in which they manage bad debts. Most are reluctant to continue to service clients with poor payment records.

Similarly, some community GPs seek payment in addition to Medical Benefits Schedule reimbursement for patients in methadone maintenance treatment. This is primarily because it is claimed that Medicare funding is not sufficient payment for the work and risks involved in treating patients on methadone maintenance therapy.

Recommendations

- Pending the outcomes of the various alternative pharmacotherapy trials, consideration should be given to broadening the spectrum of SMS to 'Specialist Pharmacotherapy Services'.
- The provision of services to those referred for pain management issues should be reviewed to ensure that these referrals are appropriate. If possible, protocols/partnerships should be established to ensure that the most appropriate services are provided for these clients.
- Analysis of unmet need for both 'generic' and Specialist Methadone Services is likely to inform future planning processes, particularly with regard to resource allocation, potential outreach services and the application of the model to non-metropolitan settings.
- Further evaluation of outcomes for SMS clients may inform future planning and development, and may allow comparison of SMS to alternative drug and alcohol treatment strategies.
- When discharging clients to community-based services, the client's capacity to pay for treatment should be identified and discussed with the client and the clinician.

Future Directions

The recommendations presented throughout this report identify specific measures to improve SMS service delivery, and these are summarised by the four headings below. Opportunities for future service development in these areas are also presented.

Access to Services

The primary concern regarding access to SMS and 'throughput' of clients is the absence of adequate numbers of participating community GP services, and to a lesser extent, community pharmacies. While it is generally agreed that entry to SMS services is generally effective, there is an understanding within the service system of the 'blockage' at the discharge end.

The recruitment of additional community methadone treatment providers is crucial to the effective provision of Specialist Methadone Services as a component of the treatment continuum. The strategies employed to encourage wider participation by clinicians have had limited success, and there is a need for new strategies to be developed in order to improve participation levels in methadone treatment. A collaborative approach to this issue is likely to be the most effective strategy in increasing the number of GPs and pharmacists actively involved in methadone treatment.

At the same time, in order to compensate for the 'geocentric' pattern of service delivery, there may also be opportunities to undertake a viability study for the provision of mobile or outreach services. This is likely to facilitate access by clients residing further from the primary service site. Similarly, further exploration of shared care opportunities, particularly with community providers in local regions may simplify the service system and improve access for geographically isolated clients. By expanding this research, consideration should be given to the application of similar models of service (or appropriate variations) in non-metropolitan regions.

Service access is also influenced by the willingness of stakeholders to refer to the service, and the intake policy of the service. The opportunities for service improvement by standardising policies and protocols are discussed in section 6.3 below.

Inter-Service Collaboration

There is a general awareness of the existence of all SMS, and given that each of the four services has now established a local profile, there are significant opportunities to promote collaboration between the SMS and community methadone and other drug treatment providers. While collaboration currently occurs, there is a significant opportunity to collectively plan and develop service strategies in a formal way.

The type and level of collaboration may vary greatly in response to regional or individual practitioner needs. For example, regional needs may demonstrate that the placement of an SMS outreach worker to provide intensive counselling/case management may improve access for clients, particularly those geographically isolated from the SMS site. Additionally, GPs may indicate that they would be happy to maintain their prescribing relationship with a client, particularly if SMS staff provided sufficient counselling support. These shared care arrangements may also facilitate a more effective discharge transition.

In addition to collaborative initiatives with treatment providers, opportunities also exist for formal collaboration, strategic planning and service development between the individual SMS. This may facilitate the development of relationships which will enable the services to learn from each other, to establish consistent work practices, and to problem solve in a unified manner to address unmet needs or difficulties common to each SMS.

Some examples of service collaboration already exist, and may be used as a basis for further interaction. For example, medical staff associated with each SMS participate as consultants with the Drug and Alcohol Clinical Advisory Services (DACAS). Similar specialist or general forums which promote interaction between the services are likely to further improve service quality.

Standardisation of Processes and Protocols

There is an opportunity to achieve greater standardisation of processes and protocols within and between SMS, thereby offering greater consistency and continuity of care.

First, standardisation may occur *within* each SMS, so that each client of the same service is treated equally to others, particularly with respect to referral to the SMS, treatment planning, review and discharge. While it was apparent that all phases of treatment were being provided, the way in which they were documented (and possibly provided) varied. This potentially allows for significant differences in the mode of treatment for each client, depending on the clinician involved. The adoption of standard work practices would also facilitate continuity of care for clients working with multiple clinicians or services, and for transfer of clients between the regional SMS.

Second, the standardisation of practices *between* each SMS may produce significant benefits to the SMS, their clients and those with a referring relationship with the service. The service system may be simpler to the client, the number of inappropriate referrals is likely to reduce and agencies working across regions would be provided with more consistent information. For example, there seems to be some variation in the way in which referrals are accepted by the SMS. While self-referral is welcome for some clients, others are required to be accompanied by a letter of referral from a medical practitioner. It may be assumed that for some referring agents who interact with more than one SMS, these variations are frustrating.

There is an opportunity for the SMS themselves to drive the process of standardising practices, as they are in a position to determine what has and has not worked, and to learn from each other. In addition to the benefits for clients and associated health professionals, it may be anticipated that information sharing and the adoption of common protocols and policies should reduce some of the administrative burden on each service.

Standardisation of Reporting and Data Collection

There is a large amount of information collected regarding SMS activity, which is often collected by both the organisation and the Alcohol and Drug Information System (ADIS). In some instances, however, the data from the different sources shows significant discrepancies. These differences appear most commonly in data elements where there is a degree of individual interpretation applied to the measure, such as achievement of goals and completion of episodes. This variation may also be attributed to the variability in completion of ADIS forms.

The issue of data reliability is important not only for internal quality performance monitoring by the service, but also in order to monitor contractual obligations between the service and the Department of Human Services.

While there is a significant amount of information collected, there remain certain performance measures for which data are not collected routinely. For example, the interim ADIS does not collect information relating to waiting times or training activities.

Client satisfaction has been measured in a variety of ways by individual services, although the regular completion of Department of Human Services Client Satisfaction Surveys should provide a more consistent insight into the level of client satisfaction with the service. Should these broad based satisfaction surveys fail to include a significant sample of SMS clients, structured surveys which seek consistent information regarding client satisfaction should be considered.

In order to minimise the discrepancies between information sources, an information strategy, which standardises the data collection for each SMS and supplies consistent information to the ADIS, should be developed. The planned provision of information from the provider to ADIS automatically will also be a welcome initiative.

Collaboration between each of the SMS to ensure that the concepts of achievement of goals and completion of episodes of care are held and applied consistently by staff is also likely to improve the consistency of activity information between each site.

In addition, the variation in program service plans for each SMS makes comparison difficult. While regional needs may indicate some variations in focus, collaboration between each SMS and the regional Department of Human Services offices may result in more consistent expectations of the services. The individual services may also benefit from taking a more active role in the negotiation process of program planning.

It should be noted, however, that while some data issues remain, there appears to have been a significant improvement in the quality of data collected by the system, and its consistency with data collected by each SMS, over the past twelve months.

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