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▶ Changing attitudes and beliefs of staff working in methadone maintenance programs.

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In Sydney in Australia an official campaign and educational efforts had the desired effect of shifting staff attitudes in methadone maintenance clinics away from achieving abstinence and withdrawal and towards long-term treatment aimed at reducing harm.

Summary The featured study sought to establish whether staff attitudes in methadone maintenance clinics in New South Wales in Australia changed as a result of an official campaign to reorient these programmes from aiming primarily for abstinence to aiming primarily to reduce harm. The data sources were two staff surveys either side of the campaign.

At the time of the first survey in 1989 health service policy on methadone maintenance was strongly abstinence-oriented: "The methadone program will have a drug-free outcome as its basic objective. Doctors and counsellors will be asked to actively pursue the withdrawal from methadone of patients whenever this can be achieved." In the second half of 1989, around the time the first survey was completed, a new policy was circulated stating that: "The principal aim of methadone treatment programs is to assist opioid-dependent persons to improve their health and social functioning and alleviate the adverse social consequences of their drug use by reducing and eliminating their illicit drug use ... Methadone treatment is also intended to complement strategies to minimise the risks of transmission of [HIV] amongst intravenous opioid users and from them to other members of the community."

To herald the change in policy, in mid-1989 a special HIV-focused issue of the health department's educational magazine for alcohol and drug treatment staff was produced. The first Australian National Methadone Conference was held in Sydney in New South Wales in 1991 and staff at public methadone units were paid to attend. Several hundred heard presentations on harm minimisation and the importance of methadone dose for retention of patients in maintenance. Staff training seminars conducted by the health

department featured speakers from the conference.

To assess the results 90 staff were surveyed at the 10 public methadone units in Sydney in 1989 and 92 at 11 of the 12 clinics operating in 1992. The surveys assessed their orientation to abstinence/ withdrawal versus maintenance as goals of methadone treatment (▶ panel), their disapproval of drug use, and their knowledge of the risks and benefits of maintenance treatment.

The Abstinence Orientation Scale

Answers are scored as positive or negative in such a way that higher total scores reflect greater orientation to abstinence.

1 Methadone maintenance patients who continue to use illicit opiates should have their dose of methadone reduced.
2 Maintenance patients who ignore repeated warnings to stop using illicit opiates should be gradually withdrawn off methadone.
3 No limits should be set on the duration of methadone maintenance.
4 Methadone should be gradually withdrawn once a maintenance patient has ceased using illicit opiates.
5 Methadone services should be expanded so that all narcotic addicts who want methadone maintenance can receive it.
6 Methadone maintenance patients who continue to abuse non-opioid drugs (eg, benzodiazepines) should have their dose of methadone reduced.
7 Abstinence from all opioids (including methadone) should be the principal goal of methadone maintenance.
8 Left to themselves, most methadone patients would stay on methadone for life.
9 Maintenance patients should only be given enough methadone to prevent the onset of withdrawals.
10 It is unethical to maintain addicts on methadone indefinitely.
11 The clinician's principal role is to prepare methadone maintenance patients for drug-free living.
12 It is unethical to deny a narcotic addict methadone maintenance.
13 Confrontation is necessary in the treatment of drug addicts.
14 The clinician should encourage patients to remain in methadone maintenance for at least three to four years.

Main findings

There was a highly significant fall between 1989 and 1992 in average abstinence orientation scores. After adjusting for other factors, the 1989 score can be interpreted as respondents agreeing with seven of the 14 items on the scale and disagreeing with the other seven. The 1992 score can be interpreted as respondents agreeing with three, being uncertain about another three, and disagreeing with the remaining eight items. Similar results were obtained from the 33 staff who answered both surveys.

However, this turning away from abstinence as an overriding goal varied across clinics. At one the score actually increased; between surveys this clinic had moved premises and seven of its nine staff left, including its doctor and its manager, a strong supporter of harm minimisation.

After allowance was made for other factors, there was no significant difference in respondents' average knowledge scores in 1989 and 1992 or in the degree to which they disapproved of drug use. In 1989 disapproval was closely related to abstinence orientation but much less closely in 1992.

The authors' conclusions

The study shows staff attitudes change with time and the process of change can probably

be facilitated by education campaigns. There was a shift in the attitudes and beliefs of staff working in public methadone units in Sydney in 1989–92 away from abstinence-oriented policies. Somewhat surprisingly, this was not associated with any change in their support for the punishment of illicit drug users or their knowledge of the benefits and risks of maintenance treatment. Staff changed their views on methadone treatment without changing their views on drug addiction or improving their fairly poor scores on a test of basic knowledge of methadone maintenance.

That the results were similar when restricted to people who had completed both surveys indicates that the change was not simply due to staff who supported abstinence being replaced by those more wedded to harm reduction. Neither did it seem to reflect a broader shift in public opinion, which remained strongly in favour of abstinence-oriented policies. The divergence of public and staff attitudes suggests the change in official policy and the accompanying educational campaign may have successfully influenced staff attitudes.

Increased support for abstinence-oriented policies at one clinic indicates that local factors – particularly influential individuals – can have a significant effect on a methadone programme's organisational culture. Policy-driven change is likely to be less successful in situations where there is opposition from those in leadership roles. To facilitate or consolidate change and improve the quality of care, more attention needs to be paid to attitudes and beliefs when selecting staff for employment and promotion in maintenance programmes.

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