ADDICTION TREATMENT

Forum

THE QUARTERLY NEWSLETTER FOR CLINICAL HEALTH CARE PROFESSIONALS ON ADDICTION TREATMENT

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Safety during MMT startup can be maximized by careful prescribing, close monitoring, & patient education.

IN THIS ISSUE

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Practice Pointers

Safely Starting Methadone in MMT

Recently, in the *Journal of Addictive Diseases*, two Canadian clinicians – Anita Srivastava, MD, and Meldon Kahan, MD [1] – reviewed the literature on methadone-related deaths during the induction phase of methadone maintenance treatment (MMT) for opioid addiction, examined current dosing guidelines, and made recommendations for improving patient safety. They described how safety during MMT startup can be maximized through careful prescribing, close monitoring, and patient education.

Risk Factors to Consider

According to Srivastava and Kahan, despite its successes as a treatment for opioid addiction, there are a significant number of deaths among MMT patients. While such deaths are tragic in themselves, they also have serious consequences for the continuation and expansion of MMT programs.

Newspaper headlines touting the dangers of methadone can do enormous harm to programs by disrupting patient access, and damaging community and government support. Thus, effective guidelines must balance the concerns of overdose deaths, public safety, treatment retention, and program survival.

The majority of deaths occur during the initial phases of MMT. Srivastava and Kahan describe a number of factors that may be involved:

1. Methadone can accumulate rapidly and unpredictably in the blood serum, in part due to variable individual

Continued on page 4

Clinical Concepts

Notes from ASAM's "Pain & Addiction" Course

Late last October, the American Society of Addiction Medicine (ASAM) launched the 7th generation of its popular 1-day seminar, "Pain & Addiction: Common Threads." A new faculty of 11 presenters, led by co-chairs – Donald Kurth, MD, FASAM, and Herbert Malinoff, MD, FACP, FASAM – conducted an intensive program attended by about 125 healthcare professionals.

Following are some notes from the day's lectures and case studies.

Doing Opioid Analgesia "Right"

Jennifer Schneider, MD, a pain practitioner from Arizona, discussed opioid therapy for chronic pain, which might be defined as pain that no longer serves as a physiological warning sign and persists for 3 to 6 months or much longer. It is a multifaceted experience, also negatively affecting emotions, thinking, memory, and other aspects of the patient's functioning.

Chronic pain management includes using medications to decrease pain and increase function. However, medications are but one part of an overall approach, which may also include physical therapy, acupuncture, massage, hypnosis, and other modalities.

Schneider observed that there are many barriers to the use of opioid analgesics, and most involve fear on the parts of prescribers and patients. Prescribers may be concerned about opioid toxicity, causing or worsening addiction, being "scammed" by patients, and regulatory

Continued on page 3

Events to Note

*For additional postings, including international meetings, see: **www.atforum.com***

February 2007

Community Anti-Drug Coalitions of America (CADCA) National Leadership Forum
February 12-15, 2007
Washington, DC
Contact: 800-54-cadca or www.cadca.org

March 2007

Medical and Scientific Conference on Addictions - Fla. Soc. Addiction Med. (FSAM)
March 1-4, 2007
Gainesville, Florida
Contact: John Harden at (866) 853-2524 or www.fsamonline.org

National Drug Treatment Conference
March 15-16, 2007
London, UK
Contact: http://www.exchangesupplies.org/conferences/conferences.html

Soc. of Behavioral Med. 28th Annual Meeting
March 21-24, 2007
Washington, DC
Contact: 414-918-3156 or http://www.sbm.org/meeting/2007/

Amer. Counseling Assoc. Convention
March 21-25, 2007
Detroit, Michigan
Contact: 800-347-6647 or http://www.counseling.org/Convention/About/TP/Home/CT2.aspx

1st Annual Conference of the International Society for the Study of Drug Policy
March 22-23, 2007
Oslo, Norway
Contact: http://www.issdp.org/conferences.htm

Later 2007

ASAM 38th Annual Meeting & Medical-Scientific Conference
April 27-29, 2007
Miami, Florida
Contact: 301-656-3920 or www.ASAM.org

7th International Conference on Pain & Chemical Dependency
June 21-24, 2007
New York City, New York
Contact: 1-800-370-9293 or http://www.iapcd.com/

AATOD (American Association for the Treatment of Opioid Dependence) Conference
October 20-24, 2007
San Diego, California
Contact:212-566-5555 or http://www.aatod.org

[To post your event announcement in AT Forum *and/or our website, fax the information to: 847-392-3937 or submit it via e-mail from www.atforum.com]*

Straight Talk... from the Editor

Addiction Myths Keep Spreading Nonsense

Persistent myths about what addiction is or isn't, and how it should or shouldn't be treated, have a capacity to distort public opinion and do great harm. *AT Forum* discussed this 5 years ago, when we wrote of Stanton Peele's assertions that "addiction is nothing more than a way of coping with life…," and most people simply outgrow their addictions (Spring 2001, Vol. 10, No. 2).

Such gibberish would be a harmless exercise in freedom of speech were it not for the fact that the books & articles of these critics distort public opinion and can do great harm.

Now, along comes the latest incarnation of this addiction mythology in a book titled *Romancing Opiates: Pharmacological Lies and the Addiction Bureaucracy* by Theodore Dalrymple. Among other allegations, this author (actually a British prison doctor writing under a fictitious name) claims that opioid addiction is a moral problem, opioid withdrawal effects are trivial, and addicts do not need medical help to stop taking drugs.

Poppycock?!

Such claims – throwbacks to 19th Century beliefs – would be harmless exercises in freedom of speech were it not for the fact that people do purchase the books of these critics. And, newspapers publish their articles, such as Dalrymple's essay, "Poppycock," in the *Wall Street Journal* last May.

He suggests that all opioid addicts fake their withdrawal symptoms. "I have witnessed thousands of addicts withdraw; and, notwithstanding the histrionic displays of suffering… I have never had any reason to fear for their safety."

He continues, "When, unbeknown to them, I have observed addicts before they entered my office, they were cheerful; in my office, they doubled up in pain... threatening suicide unless I gave them what they wanted. When refused... a few laughed and confessed that it had been worth a try."

"It is not true either that addicts cannot give up without the help of an apparatus of medical and paramedical care," he alleges. "In China, millions of Chinese addicts gave up with only minimal help: Mao Tse-Tung's credible offer to shoot them if they did not. There is thus no question that Mao was the greatest drug-addiction therapist in history."

The absurdity of proclaiming as effective "therapy" the inhumane schemes of a communist tyrant speaks for itself. Indeed, Dalrymple's prejudiced perspectives without a shred of credible clinical evidence to support them might be the true poppycock, or senseless talk, in all of this.

Pharmacohegemony?!

More recently, in an online debate last October (2006) hosted by FrontPageMagazine.com, Dalrymple said that medical treatment for addiction "often does tangible harm… by persuading addicts that they 'need' the help of professionals to stop. This, of course, is all to the advantage of a group of professionals."

As if agreeing, an addiction-treatment provider on the panel, who should have known better, claimed that the treatment of addiction with medications like methadone or buprenorphine "is based on an unproven and phony theory that opioid addiction causes irreversible 'metabolic lesions' that can only be treated with replacement therapy. …. This acceptance of replacement therapy is so well-entrenched and the use of methadone so widespread that I call this 'pharmacohegemony.'"

Thus, using a fancy made-up term, he blatantly dismissed decades of scientific research supporting the benefits of medication-assisted addiction treatment.

Evil Ancestors?!

Then, just when we thought we had heard it all, last November (2006) there was a press release from the Spiritual Science Research Foundation (SSRF) in Australia. They claim 96% of all addictions are "caused due to possession by either ghosts or our departed ancestors."

"Only 4% of addictions can be attributed to physical or psychological factors." As a cure, SSRF recommends their 3-step spiritual treatment program *[no 12 steps for them]*, which they say has had "a 100% success rate in dozens of cases over a wide range of addictions from alcohol, to cigarettes, to drugs." All it takes is "the person's desire to kick the habit."

Continued on page 3

From Editor… continued from page 2

A Voice of Reason…

A lone voice of reason came during the FrontPageMagazine.com debate noted above from a person in recovery from opioid addiction: "There are no perfect solutions for drug treatment but to deny any and all successes that have been made so far or to say that the whole rationale of treatment is flawed is irresponsible – especially when no alternative is suggested. It takes no courage to criticize an imperfect approach."

"Those who have not suffered from addiction tend to suggest simplistic non-tolerant, holier than thou approaches. Additionally, the constant belittling of addicts and treating them as less than human makes many of the critics of current treatment options, just that – critics – but they fail to make any real contributions or humane suggestions of dealing with the problem," he said.

Meanwhile, there is the nagging question of what patients and professionals in the addiction treatment field can or should do about those critics. We encourage readers to participate in our survey on this subject in this edition (see below).

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NEW SURVEY: Fighting Myths?

As a followup to the editorial in this issue, *please respond to the following survey questions:*

1. What do you believe MMT staff or patients should do about addiction myths in the media? ❑ Write complaint letters to publishers and news editors; ❑ Boycott news media that spread myths; ❑ Protest to political leaders; ❑ Do nothing; or ❑ Other_____.
2. Besides 'nothing,' have you ever done any of the above? ❑ Yes; ❑ No.
3. If so, what did you do? (specify) _____.
4. Are you responding as ❑ an MMT patient, or ❑ MMT clinic staff member or other?

There are several ways to respond to* AT Forum *surveys: **A.** provide your answers on the postage-free feedback card in this issue; **B.** write, fax, or e-mail [info above]; or, **C.** visit our website to respond online. As always, your written comments are important.

ASAM Course Notes... continued from page 1

agency scrutiny. Similarly, patients may fear opioid side effects and the possibility of addiction (or addiction relapse). However, she pointed out that, in persons with a history of substance abuse or addiction, undertreated pain itself poses a risk of drug relapse.

Even after decades of research no new categories of pain relievers have been discovered. Oploid analgesics are still very essential.

Tolerance to the pain-relieving effect of opioid analgesics is uncommon, Schneider noted. Unless there is a change in the underlying disease state, she observed that many patients continue on the same opioid dose for years.

In chronic pain, she proposed that there are several advantages of using long-acting opioid analgesics: 1) they are "single entity" without acetaminophen or aspirin to increase their toxicity, 2) they achieve smoother blood levels to provide stable pain relief, 3) a longer duration of action is provided at lower overall doses than shorter-acting agents, and 4) patients may experience better sleep.

Schneider emphasized that opioid analgesic therapy should be initiated with conservative doses and titrated upward as appropriate. For breakthrough pain, short-acting opioids can be prescribed as needed. In patients maintained on opioids, including those in methadone maintenance treatment (MMT) for addiction, opioid agonists/antagonists (e.g., buprenorphine) and antagonists (e.g., naltrexone) must be avoided.

[Also see, "Treating chronic pain in MMT Patients." AT Forum, *Summer 2006 (Vol. 15, No.3).]*

In patients with a history of substance abuse/addiction, Schneider said the research indicates that those without poly-substance abuse, with good family support, and participating in support groups (e.g., 12-step programs) have better outcomes. She stressed that pain practitioners should provide increased structure and patient monitoring, and work closely with the patient's recovery program.

Opioids Not Always the Solution

Jianren Mao, MD, PhD, of Harvard University, observed that even after decades of research no new categories of pain relievers have been discovered and opioid analgesics are still very essential. Most opioids, with a few exceptions, do not have a ceiling effect; that is, increasing doses produce greater pain relief without any upper limit. However, Mao suggested that hyperalgesia (increased pain sensitivity) during opioid therapy is possible; therefore, when little additional pain relief is achieved, tapering (lowering) the opioid dose actually may improve pain control.

However, Edward Covington, MD, with the Cleveland Clinic Foundation, conceded that there are almost no clinical studies of opioid analgesic tapering or weaning strategies, and few trials reporting on the benefits of this, so most of what is known is based on "recipe swapping" among healthcare providers.

As previously suggested, Covington agreed that when opioids no longer provide benefits for a patient – such as desired analgesia and functionality improvements – they might be stopped, just as any other drug would be.

In a practical sense, Covington acknowledged that there is no "best way" to wean patients from opioids. In all cases, withdrawal symptoms should be expected and treated with adjunctive medications.

Finally, he observed that buprenorphine is one of the most difficult opioids to discontinue, particularly at the end of the taper when a patient may be receiving only 1 or 2 mg per dose. A switch to morphine can make it easier to achieve complete weaning, he suggested.

CPS Dilemmas

Throughout the day, there was much concern expressed about patients with pain abusing their opioid medications or exhibiting addiction behaviors, and this was related to the phenomenon of "Chronic Pain Syndrome (CPS)." Essentially, CPS is chronic pain that becomes an all-consuming and incapacitating psychological disorder.

The patient with CPS develops a preoccupation with body functioning, a lifestyle centered on seeking pain relief, negative behaviors despite adverse consequences, and psychosocial dysfunctions that the patient blames on pain (e.g., anger, depression, anxiety, substance abuse, social isolation, etc.). The suffering associated with CPS can become progressively worse, and parallels with the disease of addiction are striking.

While CPS was presented during the lectures and case study discussions as a bona fide diagnosis, there could be concerns with this. Attendees were cautioned about leaping too quickly to a diagnosis of opioid addiction in patients exhibiting seemingly undesirable behaviors regarding their medication, Similarly, a misdiagnosis of CPS could have negative

Continued on page 4

ASAM Course Notes... continued from page 3

consequences in how patients are treated.

In actuality, these patients may be reacting to pain that has been undertreated or mistreated. *[See Survey Results in this edition of* AT Forum; *page 8.]* Rather than CPS, the presumed aberrant behaviors might reflect patients' dealings with a healthcare system that has been unresponsive to their needs, resulting in frustration, anger, and other problems.

"Hedonic Tone" Connection

To complete the day, Edwin Salsitz, MD, FASAM, from Beth Israel Medical Center, New York, presented his interesting concept of the relationship between pain, addiction, and hedonic tone. The term "hedonic" relates to one's sense of pleasure. Good hedonic tone provides a sense of well being, happiness, and contentment. Conversely, poor hedonic tone deprives the person of a sense of joy, comfort, or satisfaction.

Anatomical centers of hedonic tone in the human brain encompass both the circuits for pleasure that drive addiction and those that process and interpret pain sensations. Technically, this is called the "mesolimbic" area.

Salsitz proposes that some persons have inherently low hedonic tone and they find that certain addictive substances raise the level to where they feel more 'normal' or comfortable. Along those lines, chronic pain can lower whatever natural hedonic tone the person might have, until their pain becomes a daily struggle with torment and suffering.

For these reasons, treating persons experiencing both addiction and chronic pain can be challenging. Salsitz suggests that the complex actions and interactions of medications used to treat each condition can be difficult to anticipate and manage. Furthermore, as suggested above, the recovery process for both pain and addiction requires attention to physical, psychosocial, spiritual, and other life factors.

Although, this approach proposed by Salsitz is somewhat theoretical and further research would be appropriate, there is support in the neurobiological literature. And, it takes into account the necessity of a holistic approach to patient care, which may be more compassionate and effective in the long run.

The next ASAM-sponsored "Pain & Addiction: Common Threads" course will be April 26, 2007 in Miami, Florida. For information see http:www.asam.org, or call 301-656-3815.

Starting Methadone... continued from page 1

metabolism of methadone and possible effects of interacting medications.

2. Polysubstance abuse is another contributing factor. One review of methadone-related deaths found evidence of polysubstance use in 92% of drug-related deaths that occurred during the first week of MMT; in nearly half of these cases, there was a known history of polydrug use.
3. Another study found that benzodiazepines were a co-intoxicant in the majority of methadone-related deaths. Benzodiazepine abuse has been reported to cause a five-fold increase in risk of fatal over-dose.
4. Low opioid tolerance can be a significant factor. This is becoming increasingly important as more patients are being initiated on methadone for prescription opioid dependence, and these patients could have a wider range of baseline tolerance than heroin users.
5. General risk factors for methadone overdose include respiratory illness, higher age, and medications that inhibit or slow methadone metabolism. Severe hepatic dysfunction also may prolong methadone metabolism.

Srivastava and Kahan caution that studies of methadone-related deaths should be interpreted with caution. Most are based on retrospective chart audits, which may be subject to hindsight bias. The mere presence of methadone in a post-mortem blood sample does not prove causality; although, it is often assumed that methadone contributed to overdose deaths, especially for those occurring during methadone startup (initial titration).

Although an overdose death can occur within a few hours after methadone ingestion, symptoms of overdose can have a subtle appearance with a variable time course. A dose that does not control withdrawal on the first day may be fatal by the 3rd or 4th day, Srivastava and Kahan observe, making it difficult for clinicians and their patients to anticipate toxic effects.

Patients can appear relatively alert when engaged in conversation or daily activities, but experience an overdose crisis during a nap or at night. Sedation may not be perceived as serious by the patient or family members, since this is what they experienced with previous opioid use. Also, patients may be more fearful of withdrawal than of overdose, and pressure MMT clinic staff to increase the dose too quickly so they won't experience withdrawal symptoms.

The authors concede that the relative risk of death at different starting or incremental doses of methadone is not known, either for the medication alone or when combined with other drugs. Nonetheless, they note, the literature suggests that methadone is a potentially dangerous drug with a narrow margin of safety during the initial titration.

Methadone startup protocols should balance risks and benefits, considering not only methadone deaths but also the need for achieving successful treatment outcomes.

Srivastava and Kahan state that the ratio between a potentially fatal single startup methadone dose of 50-70 mg and a maximum-recommended initial methadone dose of 30 mg is approximately 2:1. As comparative examples, the lethal-to-therapeutic ratios for phenytoin, acetaminophen, and desipramine are 6:1, and 10:1 and 20:1, respectively. Thus, methadone has a relatively narrow safety margin for overdose compared with some other medications. *[However, accurately defining the lethal dose of methadone is difficult – see* ***Box*** *on page 7.]*

While caution is necessary with methadone induction doses, the authors recommend that this must be balanced against treatment needs. Higher methadone doses have been shown to reduce opioid use and increase treatment retention. A lower initial dose will extend the time required to reach the optimal dose by 1 to 2 weeks, prolong the patient's substance abuse, and increase the risk of overdose. Finally, early weeks of MMT often are associated with high drop-out rates, and lower starting doses may have a further negative influence.

Therefore, methadone induction-dosing protocols should balance risks and benefits, considering not only methadone deaths but also treatment retention and achieving illicit opioid abstinence as quickly as possible.

Suggested Guidelines

Taking into consideration the limited evidence on methadone-related deaths, Srivastava and Kahan developed guidelines that they believe: A) incorporate the best available evidence to date, B) balance the need for safety with the need to retain patients in treatment, and C) allow for the reality that many patients use other substances that could contribute to fatal overdoses in combination with methadone.

The authors reviewed methadone-

Continued on page 5

Starting Methadone... cont. from page 4

induction dosing guidelines from the U.S., Canada, Britain, Australia, and other countries. Recommended first-day starting doses ranged widely between 10 mg up to 40 mg, depending on estimated opioid tolerance in the patient. Two countries (Ireland and Spain) allowed first-day dosing up to 60 mg.

U.S. Federal regulations recommend a maximum first dose in patients actively abusing opioids of up to 30 mg methadone.[2,3] If withdrawal symptoms persist at 2-4 hours, an additional 5-10 mg is allowed, but the total first-day methadone dose cannot exceed 40 mg *unless* the program physician specifically documents the necessity for more.[2, also see ***Box*** *on page 7]*

In general, Srivastava and Kahan [1] recommend an initial methadone dose of no more than 30 mg, or 10-20 mg for high-risk patients. Dose increases should be no more than 5-15 mg every 3 to 5 days, with a total weekly increase of no more than 20 mg for high-risk patients. Any increases in the 10-15 mg range should be only for patients who remain in withdrawal for much or most of the day. See the ***Table***, and the authors' notes as follows:

Methadone Induction Protocol

Initial dose – *low* risk	Maximum 30 mg oral methadone.
Initial dose – *high* risk	10-20 mg oral methadone.
Dose increase – *low* risk	• 5-15 mg every 3-5 days. • 15 mg only if in withdrawal most of the day.
Dose increase – *high* risk	• 5-15 mg every 3-5 days. • 15 mg increase only if withdrawal most of the day. • Maximum 20 mg increase per week.
Definition of high risk	• Over age 65. • Respiratory disease or hepatic dysfunction. • Taking CYP 3A4 inhibitors. • Taking sedating medications such as benzodiazepines, antidepressants, antihistamines, antipsychotics. • Lower baseline opioid tolerance.
Estimation of baseline opioid tolerance	Lower tolerance possible if: non-daily use of opioids, or oral use of codeine, or < 200 mg morphine equivalent/day.
Take-home doses	No take-home doses in first two weeks.*
Monitoring	Assessed by physician at least twice per week, several hours after dosing.
Missed doses	• Do not increase current dose for 1 or 2 days. • Restart at initial dose if 2 consecutive doses are missed.
Patient education	• Take methadone in morning. • Avoid alcohol, sedating drugs, and triggers. • Have family member call clinic or emergency number at first sign of toxicity. • Do not take substances to relieve withdrawal symptoms; however, if you do, take 10 hours after last methadone dose. • Check with a physician before discontinuation or initiation of any medications.

Adapted from Srivastava and Kahan 2006.[1]
*U.S. Federal Regulations allow for 1 take-home dose if clinic is closed on Sunday or a holiday.[2,3]

Defining "Higher Risk"

High-risk patients include those over age 65, those with underlying respiratory disease or severe hepatic dysfunction, and those taking cytochrome P3A4 inhibitors (such as quinolone or macrolide antibiotics, fluconazole, and some SSRIs). Also at high risk are patients on any sedating medication, including benzodiazepines, antidepressants, sedating antihistamines, and antipsychotics. Patients who might have a lower baseline opioid tolerance are also at high risk.

Lower Opioid Tolerance

Lower tolerance might be expected in patients who do not use opioids daily or who are taking oral opioids at 'moderately high' doses (e.g., codeine, or less than 200 mg of oral morphine or its equivalent). Establishing opioid use can be difficult; patients might exaggerate their use to get on methadone, or they simply may not remember how much they take day to day.

The reliability of a tolerance estimate might be aided by obtaining corroborating information from other physicians or family members, and by confirmation of opioid use through high-precision urine drug testing. If there is doubt regarding the patient's level of tolerance, it is safer to use the lower initial dose.

Special Precautions

To help avoid methadone-drug interactions, patients should be advised to check with MMT staff prior to taking any newly prescribed medications. *[For current tables of potentially interacting substances see: http://www.atforum.com/SiteRoot/pages/addiction_resources/Drug_Interactions.pdf.]*

Sedating drugs should not be prescribed unless the patient has already been on a moderate dose of those medications daily for at least 2 months and the clinician is confident the patient is compliant. Such patients should receive lower initial methadone doses. Patients dependent on high daily doses of street benzodiazepines should be tapered off of them, preferably in an inpatient setting, before initiating methadone.

Patients who binge on alcohol or benzodiazepines are perhaps the most difficult group to manage. It might be necessary to assess and observe such patients before and several hours after each methadone dose, particularly on the 3rd or 4th day after a dose increase. Methadone titration on an inpatient basis should be considered, if available.

Take-Home Doses

The patient should not be given take-home bottles of methadone during the initial titration, even if family members agree to dispense it. In fact, this can lead to problems including the dangerous possibility that family members may dispense the medication incorrectly, divert it, or use it for personal consumption. *[In the U.S., this could mean that startup dosing should not be initiated close to a Sunday or holiday when the clinic will be closed and a take home dose allowed.]*

Monitoring

The patient should be assessed by the clinic physician at least twice per week, preferably several hours after the patient's dose. Within the bounds of confidentiality, a patient's family members or significant others should be asked to report on the patient's response to methadone. Patients and, ideally, their families or significant others should be alerted to symptoms of overdose, and told to contact the clinic or emergency services at the first sign of toxicity. Higher-risk patients may require very close monitoring.

Missed Doses

Patients who miss a dose during the initial titration period may lose some tolerance to methadone, and their current dose should be extended without increase for 1 or 2 days. Titration should be restarted at the initial dose if 2 consecutive doses are missed.

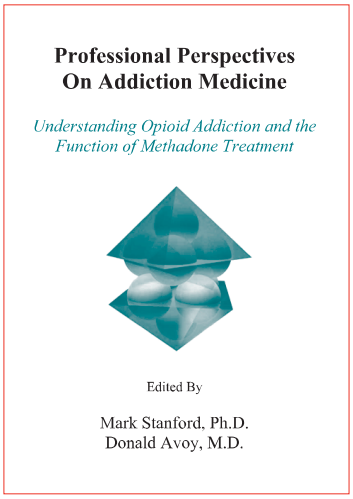
Patient Education

The patient should be advised to take methadone in the morning and to avoid alcohol or sedating drugs (e.g., benzodiazepines, antihistamines). Clinic staff should explain the risks of taking drugs to relieve withdrawal symptoms, and point out that ongoing illicit opioid abuse will only delay the time to reach the optimal methadone dose.

Finally, Srivastava and Kahan advise that patients who persist in using drugs to relieve withdrawal symptoms should be cautioned

Continued on page 7

New Book Aids Understanding of MMT



Among the many articles, pamphlets, and booklets of all sorts seeking to explain how methadone maintenance treatment (MMT) really works, this book stands out most favorably. *Professional Perspectives on Addiction Medicine; Understanding Opioid Addiction and the Function of Methadone Treatment* is a long title for a rather brief and compact book (120 pages, 5" x 8") that is authoritative, comprehensive, and very easy to read.

Edited by two experienced practitioners in the field – Mark Stanford, PhD, and Donald Avoy, MD – authors of the book's 8 chapters include such well-known clinicians as Joan Zweben, PhD, Judith Martin, MD, Robert Kahn, PhD, and others. The document was developed under the auspices of the Santa Clara Valley Health & Hospital System, Department of Alcohol & Drug Services (DADS), San Jose, CA.

As a bonus, the book can be downloaded as a PDF document free of charge at ATForum.com or printed copies can be ordered at a nominal charge. See instructions below.

Widespread Appeal

We agree with the editors that, "It's not difficult to obtain a variety of opinions about methadone… and many of them would be quite negative and unfounded." Their expectation for this new book – published in 2006, but just recently updated in November 2006 – is to promote increased awareness about MMT, its foundation in evidence-based science, and its effectiveness in treating opioid addiction.

While the editors suggest the book would be particularly important for persons outside the methadone treatment field, we believe it has importance for everyone with an interest in the treatment of opioid addiction. It definitely should be read by all MMT clinic staff and they should strongly recommend it to community leaders, law enforcement personnel, educators, and others. Many current or prospective MMT patients, and their loved ones, also could benefit.

Authoritative Yet Accessible

The text is easy to follow and all medical terms are clearly defined, so readers without medical training will find the book understandable. Yet, the authors do not shy away from what otherwise could be overly complex subjects.

Exemplifying this approach is the title of Chapter 3 written by Stanford: "The Behavioral Pharmacology of Methadone: The Easy-to-Understand Version." This is an important subject, which would be off-putting for some readers were it not for Stanford's clear explanations using everyday language.

Stanford introduces the ironic appeal of heroin with a quote from actor Robert Downy, Jr., "Heroin addiction: It's like I've got a shotgun in my mouth, my finger's on the trigger and I like the taste of gun metal." Stanford continues in a mere 15 pages to clearly explain how opioids in general work in the brain and how methadone, at an optimally *adequate* dose, serves to stabilize brain function that has run amok.

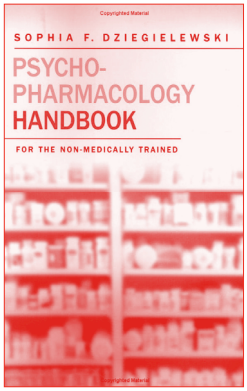
Like all chapters in the book, this one is based on scientific evidence and references for relevant literature are provided. In fact, the ample references to authoritative resources consulted in developing the book set it apart from most other literature of this type intended for a broad audience.

Other chapters cover such subjects as outcomes of MMT, effects of co-occurring mental health issues, methadone and pregnancy, and more. A final chapter explores myths, misunderstandings, and stigma surrounding methadone. There also is a very well-written perspective from a patient who tried every other treatment imaginable before finding that MMT really does work best for a great many persons seeking addiction recovery.

How to get a copy…

The Adobe® PDF version of this book – *Professional Perspectives on Addiction Medicine…* – can be downloaded at the *AT Forum* website:http://www.atforum.com/SiteRoot/pages/addiction_resources/MMT_book_2006.pdf. Toward the end of the PDF document is a form for ordering bound, paper copies of the book by mail, at $6.50 each plus shipping and handling.

Text Sheds Light on Psychopharmacology



Unquestionably, a large number of patients coming into methadone maintenance treatment (MMT) programs today have co-occurring mental or psychological disorders of some sort. And, most of those persons are already taking or will be prescribed medications for those afflictions, an aspect of medicine called "psychopharmacology."

Therefore, a new book – *Psychopharmacology Handbook for the Non-Medically Trained* – serves a vital need for MMT clinic staff who would benefit from a better understanding of those medications.

As the title implies, this 270-page text could be invaluable for MMT clinic staff who might be considered non-medically trained: counselors, therapists, social workers, and others who have patient contact. These persons need to understand the variety of medications patients may be taking, their actions, typical dosages, side effects, and expected impact on recovery from both addiction and mental illness.

At the same time, since medically trained providers – nurses and physicians – absolutely need such knowledge, this book could serve them well in broadening their education. Even the most experienced or psychiatrically trained medical staff might find this book to be an excellent review and a handy reference text.

Whether medically trained or not, MMT staff must spend time educating patients, their family members, and others about the benefits of combining medication regimens with effective psychosocial strategies. This book can help provide necessary knowledge.

The author, Sophia M. Dziegielewski, PhD, LCSW, is Professor and Dean of the School for Social Work at the University of Cincinnati. She has researched and written more than 95 publications, and is the recipient of numerous honors and awards for her teaching. She is a source to which students and professionals alike have turned for up-to-date, accurate information on psychopharmacology.

Although Dziegielewski writes in a

Continued on page 7

Resource Reviews… continued from page 6

straightforward manner, the subject is by its nature technical and there is a great deal of material covered. Some of the subjects include:

- An introduction to psychotropic drugs and the culture of today's mental health treatments;
- How medications work: the basics of medication prescription and their use;
- The role of the non-medically trained mental health practitioner;
- Medications used to treat depression-related symptoms;
- Medications used to stabilize bipolar mood disorders;
- Medications used to treat symptoms of anxiety;
- Schizophrenia and the psychotic disorders;
- The role of herbal preparations, essential oils, and flower essences;
- Psychopharmacology in special populations.

The book has many reference tables providing at-a-glance summaries of key information. Throughout, there also are "Quick Tips" sections giving helpful suggestions for increasing medication compliance, coaching patients in using their medications properly, assessing signs of anxiety, and dozens of other topics.

Readers may want to first skim the book to get a broad impression of its contents, then read sections that are of immediate interest, and then retain the book for reference when medication issues arise in particular patients. One short-coming is that the book was not designed to specifically address potential interactions of the covered medications with methadone, and such interactions can be frequently problematic. Therefore, as a companion to this book, readers may want to consult the *AT Forum* paper on "Methadone-Drug Interactions" (available online at: http://www.atforum.com/SiteRoot/pages/addiction_resources/Drug_Interactions.pdf).

Where to get this book…

Psychopharmacology Handbook for the Non-Medically Trained is available from the publisher, W.W. Norton, New York at: http://www.wwnorton.com/orders/npb/070459.htm (ISBN: 0-393-70459-9; publication date July 2006; hardcover; 240 pages; list price $27.50). It also is available at discount prices from http://www.amazon.com and at other online booksellers.

Starting Methadone… continued from page 5

to take the drug only when they are in severe withdrawal and at least 10 hours after taking methadone. Patients should use only the smallest amount of drug necessary to relieve withdrawal symptoms, and to avoid alcohol, benzodiazepines, and street methadone. If possible, they should stay with supportive friends or family, and avoid contact with drug users or other drug-using triggers.

Guideline Validation

As a form of validation, Srivastava and Kahan distributed their recommended guidelines described above to all methadone-licensed physicians in the province of Ontario. Their consensus indicated that the proposed methadone-induction guidelines were reasonable and in keeping with the collective clinical experience of the several hundred physicians surveyed.

Given the vulnerability and variability of patients seeking treatment for opioid addiction, it is important that MMT clinic staff exercise caution during the induction phase of methadone treatment. According to Srivastava and Kahan, evidence suggests that physician training and education, including the wide dissemination of guidelines such as these, can lower methadone-related overdose and death rates.

1. Srivastava A, Kahan M. Methadone induction doses: are our current practices safe? J Addict Dis. 2006;25(3):5-13.
2. Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2005. DHHS Publication No. (SMA) 05-4048.
3. Leavitt SB. Methadone Dosing & Safety in the Treatment of Opioid Addiction. Addiction Treatment Forum [special report]. 2003(October). Available online at: http://www.atforum.com/SiteRoot/pages/addiction_resources/DosingandSafetyWP.pdf.
4. Center for Substance Abuse Treatment. Methadone-Associated Mortality: Background Briefing Report. CSAT Publication No. xx-xx. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2004.
5. Bakker A, Fazey C. Practice controversy: methadone tolerance testing in drug misusers. Br Med J. 2006;333:1056-1059.

How Much Startup Methadone is Enough?

In proper balance it should be noted that, through the years various approaches to methadone induction for MMT have been used; some more rapid than others, and some using higher doses than guidelines recommend. Current U.S. Federal regulations *do allow* for greater than 40 mg of methadone the first day if the program physician documents that more was required to suppress opioid withdrawal signs/symptoms.[2]

Furthermore, forensic research has shown that serum methadone levels (SMLs) associated with deaths and those considered therapeutic during MMT (or safe in opioid-tolerant individuals) overlap considerably. And, due to a variety of factors there usually is only a weak correlation between methadone dose and SMLs across patients.[2,3] Therefore, it is doubtful that any single methadone dose could be considered as inherently lethal in *all* opioid-addicted patients coming into MMT.[4]

Recently, in the November 18, 2006 edition of the *British Medical Journal*, clinicians Adam Bakker and Cindy Fazey reported matching the starting dose of methadone to patients' predicted opioid tolerance levels and using starting doses of up to 150 mg of methadone. They acknowledge, "despite our use of starting doses that *[government authorities]* might well consider irresponsible, the only drug-related deaths in our series occurred after methadone had been discontinued."[5]

These practitioners used an approach termed "methadone tolerance testing," which involved careful questioning of patients regarding their prior opioid use and patterns of opioid withdrawal, and educating patients about the dangers of overdose risks if they misrepresented such opioid use. A starting, trial dose of methadone was matched to each patient's estimated tolerance level and the patient was monitored very closely for signs of overdose.

Bakker and Fazey note that, "Our patients know they will be observed and that naloxone will be used if needed *[to reverse methadone effects]*. In practice, patients' judgment of their dose requirement has proved accurate, and … addicts who request high doses are likely to be those who *[adapt]* most readily and are thus least likely to succumb to accumulation."

While this controversial approach could be risky and might not be recommended as routine, the authors assert that inadequately low methadone starting doses do not eliminate mortality. If the amount of methadone is less than their opioid requirement, patients will usually supplement it with illicit heroin, benzodiazepines, or other drugs until they have reached – or dangerously exceeded – their comfort level.

Survey Results: Mistreated Pain in MMT?

The *AT Forum* Spring 2006 edition (Vol.15, No. 2) featured an article on the "Perils of Pain in MMT." A followup reader survey asked about the mistreatment of pain among methadone maintenance treatment (MMT) patients.

The article noted that pain is a highly prevalent problem in MMT patients, with up to 4 out of 5 in some studies complaining of chronic pain. However, there were suspicions that these conditions often were being *mistreated* – either undertreated, untreated, or otherwise mismanaged.

Mistreated Pain is Commonplace

There were 186 responses to the survey, with the majority (61%) clinic staff members, 39% patients, and 4% "other." Percentages of respondents who believed that MMT patients are indeed mistreated for their pain were overwhelming (see upper ***Graph***); although, staff members seemed less inclined to acknowledge this.

Such mistreatment also occurs very often (see lower ***Graph***). Again, MMT clinic staff were reluctant to portray the problem as nearly universal; however, only 1 in 10 of them believe that pain mistreatment rarely or never occurs.

Many Sources of Mistreatment

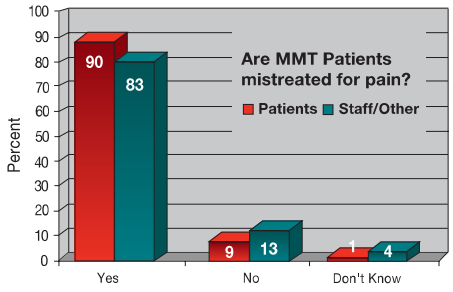
Where does the mistreatment of MMT patients' pain occur? A majority of respondents (77%) indicated that private physicians most often provide inadequate treatment. Another 65% and 62% noted that pain mistreatment occurs in hospital emergency departments and during inpatient hospitalizations, respectively.

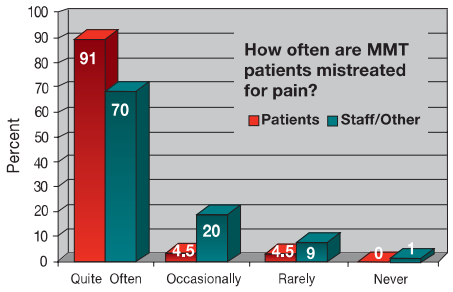
One third (33%) indicated pain clinics as providing deficient treatment, and 41% felt that MMT clinics do not provide adequate pain management. Percentages total to more than 100 because respondents could check all categories that applied.

As might be expected, these results suggest that healthcare providers with less training and experience in treating either pain or MMT patients tend to mismanage the pain. This implies that MMT patients must be somewhat selective in where they go for pain treatment and there is a need for better education of healthcare providers regarding pain management in this patient population.

Stigma, Ignorance are Barriers

In their comments, several respondents noted as a barrier the common misunderstanding among healthcare providers that methadone offers pain relief during MMT. And, patients who justifiably complain are assumed to be "drug seeking" and then denied adequate treatment.





An MMT staff member observed, "I had a patient who was denied her regular methadone maintenance dose in the hospital because they had already given her a small amount of morphine for pain."

One patient wrote, "Most pain doctors won't even evaluate you if you tell them you're on MMT."

An MMT clinic director said that they send a letter to patients' primary care physicians informing them about principles of pain management for their patients. However, a patient commented that staff at her MMT clinic become suspicious when patients are prescribed opioid pain medications by outside physicians.

Clearly, there is a need for greater understanding as well much more effective communication among all healthcare providers who might be involved in the management of pain in MMT patients.

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