ADDICTION TREATMENT

Forum

THE QUARTERLY NEWSLETTER OF ADDICTION TREATMENT FOR CLINICAL HEALTH CARE PROFESSIONALS

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PREMIER EDITION

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Viewpoint...

Nina Peyser, Beth Israel Medical Center

Myths and Misunderstandings Hinder Addiction Treatment

A.T.F. interviewed Nina Peyser, Executive Director of the Chemical Dependency Institute at Beth Israel Medical Center in New York, to learn of her views regarding addiction treatment. Following are excerpts from our hour-long discussion with her:

A.T. Forum: Nina, how would you define "addiction?"

NINA PEYSER: I would characterize addiction as a chronic, relapsing disease that is both preventable and treatable. There are many things about addiction that are misunderstood, ignored or misrepresented by government policy. Addiction is not a problem of sociopaths. It's not a problem of criminals. It's not a problem that can be resolved by interdiction, arrest or incarceration. It certainly presents problems for society to deal with, but those are the ramifications of addiction. The addiction itself is a primary medical disease that an individual suffers.

A.T.F.: Is this view controversial?

PEYSER: It's controversial to the

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Current Comments

Attitudes Regarding MMTP to Change, Says Dole

Vincent Dole, M.D., a developer of MMT, is still an outspoken proponent of the approach. In a *JAMA* commentary ["Hazards of Process Regulations," April 22/29, 1992, p. 2234] he states:

"Despite regulatory constraints and suboptimal performance by many programs, methadone maintenance has grown to worldwide application.... At present, there is no alternative treatment for heroin addiction with comparable success in retention of patients, in reduction of drug abuse, and in social rehabilitation. Given the urgency of the problem of the acquired immunodeficiency syndrome and the direct linkage of the infection to drug abuse ... it is remarkable that serious opposition to the treatment continues. ... With no large-scale alternative available, one wonders about the motives of persons who prefer to have addicts continue to buy heroin on the streets rather than receive medicine prescribed by a physician."

Yet, over the years, Dr. Dole has not been without severe critics. Reacting to an earlier article by Dole, the following appeared in a letter to the editor of *JAMA* [February 2, 1990, p. 658]:

"Dr. Dole implies that there are no reasonable medical arguments against the methadone program.

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Straight Talk... from the Editor

This is YOUR Forum; We Look Forward to Hearing from You

Few publications have specifically addressed your needs, aired your concerns or served as a platform for your accomplishments.

Welcome to this premier edition of the *A.T. Forum* — a meeting place in print for professionals working in addiction treatment programs. It should be no surprise to our readers that the treatment of persons with drug addictions has a long history, yet it is still shrouded in many myths and misunderstandings.

As health care professionals, you have been the front line troops on the battlefield of drug addiction. Few publications have specifically addressed your needs, aired your concerns or served as a platform for your accomplishments. This independently published, quarterly newsletter is available to you at no charge. It is funded by an educational grant from Mallinckrodt Specialty Chemicals Company, St. Louis, MO.

It is your Forum. Our goal is to serve as reporters of what has happened, what is happening today and what might happen to further your success in treating drug addiction. Our purpose is not to promulgate a specific philosophy or approach; at all times, we will strive for objectivity.

Recognizing your desires to keep current, yet the limited personal time you have for reading professional literature, we will keep our articles brief and pointed; a "quick-read" during moments of leisure time. Yet, we will always reference our sources, so you can access the complete text if you so desire.

Aside from excerpting published news reports and journal articles, we will also be doing first-hand interviews, notes on upcoming events of interest, profiles of patients and professionals, and providing other information we expect will be of interest to you.

Your own participation will be crucial and most welcomed. Send us your thoughts, comments, criticisms and news of what you are doing . These will truly make this newsletter a "forum" representing the views of all addiction treatment professionals. Use the feedback card attached to this issue, or write to us at: *A.T. Forum*; 1515 Woodfield Rd.; Suite 740; Schaumburg, IL 60173. Be certain to include your name and a phone number where we can reach you during business hours to verify information. ALL reader responses will be acknowledged.

We're looking forward to hearing from you and hope you find the *A.T. Forum* informative and helpful.

Stewart B. Leavitt, Ph.D., Editor

National Methadone Conference '92

The American Methadone Treatment Association is sponsoring a conference focusing on comprehensive addiction treatment, November 8-11 at the Buena Vista Palace Hotel in Orlando Florida. The conference will be hosted by the Florida Department of Health & Rehabilitative Services. For details, please contact the American Methadone Treatment Association, 253-55 Third Avenue, New York, New York 10010.

Methadone Symposium Nov. 17

Drug abuse treatment professionals will not want to miss the first "Addiction Treatment Forum," a one day symposium to be held November 17, 1992 at the Lisle/Naperville Hilton. Topics of discussion will include the viability of Methadone treatment, adequacy of dosage levels, other treatment options and the 12-step process.

Speakers will include Dr. Ed Senay and Dr. Andrea Barthwell from Interventions in Chicago, Dr. Mary Jane Kreek from the Rockefeller Medical Center in NewYork, Dr. Thomas Payte from San Antonio, Mark Parrino, President of the American Methadone Treatment Association, and Eldoris Mason, President and CEO from the BRASS foundation.

The symposium is being sponsored by Interventions, BRASS, The Illinois Alcoholism and Drug Dependence Association (IADDA), and is made possible by an educational grant from Mallinckrodt Specialty Chemicals Company. For more information, please fill out and return the reply card in this issue of A.T.F. A.T.F.

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Current Comments...

Methadone is an opiate on the supply side and it is medically irrelevant whether it is legal or illegal. The use of a psychoactive drug that creates drug dependence (a disease) in a `treatment plan' is contorted thinking. ..."

"The medical profession itself is bankrupt if it promotes distribution of a class I synthetic opiate under the guise of treatment. To promote enslavement to any psychodrug is morally reprehensible and unacceptable as either medical or public policy. ... Using the acquired immunodeficiency syndrome epidemic to promote methadone simply changes the mode of death."

[Signed] Paul M. D'Amico, DO; American Osteopathic Academy of Addictionology; American Society of Addiction Medicine; Livingston Manor, NY.

In his recent commentary, Dr. Dole observes that until recently there was "no teaching on the subject of addiction in medical schools," and senior faculty members conveyed attitudes of distaste and contempt for addicts. "For the majority of physicians — teachers and practitioners of the past generation — addictions were moral problems, a sign of depraved character, not diseases. This attitude is still prevalent."

Dole believes such attitudes are unlikely to persist in mainstream medicine beyond the present generation. "A judgemental attitude is inconsistent with current advances in neurobiology. Behavior can now be seen as more dependent on neurochemical processes than was recognized by our teachers. True patient-oriented treatment guidelines will emerge when the medical profession insists on applying the same standards to chemotherapy in addictions as it applies to chemotherapy in infectious disease, cancer, schizophrenia, depression, and endocrine disorders."

At present, there is no alternative treatment for heroin addiction with comparable success

A.T.F.

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Research Review...

had correspondingly longer lengths of time in treatment.

In a companion editorial commenting on the survey ["Ineffective Use of Psychoactive Drugs," *JAMA*, January 8, 1992, 281-282], James R . Cooper, M.D. states, "Ineffective methadone dosing increases the probability of continued illicit intravenous narcotic use and, hence, increases the risk of exposure to human immunodeficiency virus infection from contaminated needles. ... More than ever before, we need to remove the remaining arbitrary state or program policy restrictions on methadone dose and duration of treatment."

Dr. Cooper suggests that physicians should insist on reevaluating patients continuing to use illicit narcotics and receiving less than 60 mg/d of methadone. In such cases, higher doses, along with behavioral and psychosocial therapy interventions, should be considered. "Increasing the methadone dosage in such patients will not eliminate all illicit intravenous narcotics use in all patients," he admits, "but it will ensure that inadequate dosing is not a contributing factor and will signal that other remedial interventions need to be vigorously pursued."

A.T.F.

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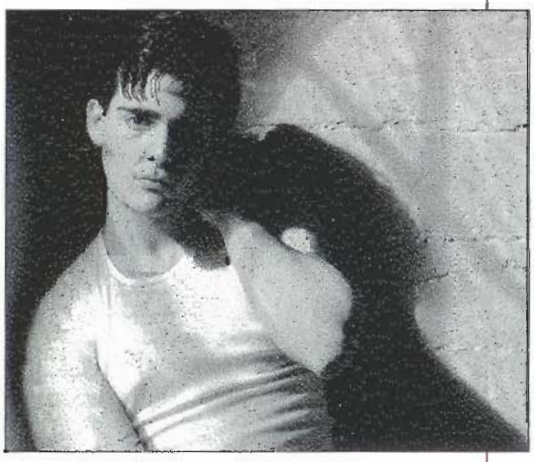
Nina Peyser...

general public. My guess is that it will be overwhelmingly accepted by addiction professionals. It will be argued against by people who think that addicts are morally bad, weak individuals who don't want to stop getting high. There are plenty of people who believe that.



A.T.F.: Aren't there more funds being devoted to drug interdiction or the penal system than there are toward the drug treatment system?

PEYSER: Our government has been misguided, misinformed, and has not acted in response to what the treatment professionals and the literature have been telling them for years and years. They have put virtually no money into treatment, very little money into prevention, and very little money into research. The research money that they're putting forth tends to be on better ways to do interdiction. Over the years, we have seen repeatedly that we cannot keep drugs out of the country, no matter what kind of drug or what kind of interdiction effort. You can't prevent an individual from using drugs. You can't stop the crime associated with the use of drugs by characterizing the individuals who are using them as criminals and, therefore, treating them in a penal sense rather than in a medical sense. It obviously doesn't work.

A.T.F.: How has this impacted your work at Beth Israel?

PEYSER: I think it fosters a climate in the general public that's an incorrect one, and it results in great harm to the treatment programs and to the patients. By perpetuating an image that drug users are criminals who should be incarcerated and that a war on drugs should be fought by trying to keep drugs out of the country — as if it was possible to do that — we have fostered a climate that does not recognize that the people who suffer from addiction have a disease that they can't just say "no" to. We've fostered a myth in which the public's view does not differentiate between an addict in recovery who is going to treatment or one who is currently using. The public views the addict as a criminal; as a bad, immoral, weak, lazy degenerate, or some variation on that theme. There is no one who will allow methadone clinics, or virtually any other kind of drug treatment facility, to open in their neighborhood because they associate addiction with crime. They don't associate addiction treatment with the good public health service that will help people get better.

A.T.F.: How has the potential for methadone diversion affected treatment programs?

PEYSER: It's a true phenomenon that some methadone patients sometimes will sell, or give away, part of their take-home medication. The question in my mind is, "Who's buying it and why?" The answer overwhelmingly is that this is not being sold to a 14-year-old kid who is experimenting with drugs. There is no such thing as neophyte drug users dabbling in methadone. People don't do that. Pushers don't sell it that way. The buyers are heroin addicts who are not in treatment; who are buying methadone illicitly rather than obtaining it from treatment programs. Then you start asking, "Why are they buying it on the street instead of in a treatment program?" Are we talking about waiting lists or no available treatment? Are we talking about people in programs that have a maximum duration of treatment? Eighteen months and you're out — that's not enough for many individuals. Then, some programs have policies of giving out far too little methadone. They only will give a patient 20mg or 30mg, and some need more. I think it's a tragedy that we're focusing on take-home dosage and possible diversion; which focuses on potential criminal behavior by the methadone patient. To me what's criminal is that there is a heroin addict out there on the street who needs methadone, and we're not providing it through some licit means!

A.T.F.

Patient's Perspective:

Methadone Furthers Function & Growth

A letter came into our offices from Doris [not her real name to respect her request for anonymity] which is excerpted here. She was referred by Stan Novick, President of the National Alliance of Methadone Advocates (NAMA).

Doris is in her mid-30's and says, "I began using narcotics twenty years ago and have spent approximately ten years in various MMTP's, having detoxified from methadone maintenance twice." For the past two years, she's been an MMT patient at a major metropolitan clinic.

"Methadone maintenance is by far the only modality which has allowed me to function and grow," she writes. "It has taken me close to ten years to accept my status ... as a methadone maintenance patient, without the constant pressure to detox.... I have been able to accomplish more in the past two years than I have in the past twenty." Doris has completed an advanced college degree, finished a number of important personal and work projects, and "participated in healthy relationships and support networks with friends and family," she says.

At the clinic, Doris pays $20 per month for daily dosage which she believes "is a relatively small price to pay for the benefits received from methadone maintenance." She picks up medication twice weekly, but is concerned by the schedule which is "stressful and burdensome." The clinic's limited hours often conflict with her work schedule and have compromised her career opportunities, she believes.

While Doris feels she gets good medical care at the clinic she attends (annual physical, GYN exam, etc.), she's critical of the lack of patient involvement in treatment decisions. She would like a reduction in her pick up schedule, but this has been denied. Over the course of her MMTP history, she's had no less than seven counselors and says, "the level of commitment, skill and chemistry varies greatly."

"It is humiliating," Doris says, "to have so much control over my life left within the unchecked discretion of people whom I neither trust nor believe have an accurate understanding or appreciation of my best interest." She feels, "As treatment progresses and the requisite lifestyle changes are made, patients' schedules should be adjusted to reflect their reduced need for supervision and clinic interaction."

"The greatest impediment in joining methadone maintenance treatment is program administration and public ignorance," she believes. Two years ago, she had an accident and became an emergency room patient. Not wanting to risk drug interaction complications, Doris told the nurse she was a methadone maintenance patient. "Immediately the nurse loudly yelled out, `We have an AIDS risk here.'" Doris felt, from that point, the attending staff treated her with more caution and less compassion. "I was embarrassed, mortified and shocked," she writes,

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"I will not seek detoxification again until I have enough resources to overcome the pain; enough courage to overcome the fear and enough faith to overcome the odds."

HIV/AIDS & IVDUs

HIV/AIDS Warning...

"Safe Sex" Danger

With all the talk advocating condom use during sexual relationships to help prevent the spread of HIV, a critical feature has tragically often been overlooked – all condoms are NOT created equal. According to *FDA Consumer* [January-February, 1992], "When it comes to protection against AIDS, natural-membrane condoms, made from lambskin, can't put up as good a defense as their latex cousins. And, according to the FDA, the labels ought to say so." [Assuming, of course, people do read and fully understand the labeling.]

Natural-membrane condoms, while much greater in expense, are often preferred over latex due to the greater comfort and sensitivity they offer. While they DO provide a measure of birth control, they may NOT provide a barrier against virus-sized particles such as those that cause HIV, hepatitis B, vaginal warts or herpes.

Many sex education programs, including the advice offered by some health professionals and in a great many of the so-called "safe sex booklets" we've seen, fail to specify the necessity of using LATEX condoms to help guard against HIV/AIDS. We hope this will be corrected. – Ed.

Epidemic Predicted, Control Measures Controversial

The spread of HIV/AIDS among intravenous drug users (IVDUs) has caused much alarm among the general public, health care practitioners and legislators. The social problems of drug addiction and the clinical challenges of effective treatment are difficult enough. These fires are now further fueled by a fatal disease readily spread among intravenous drug users. This regularly appearing column focuses on the extent of the problems and programs, practices and legislation affecting their control. – Ed.

According to the International AIDS Center at Harvard University's School of Public Health, the AIDS epidemic is accelerating and may reach 120 million people worldwide by the year 2000. "At a minimum, more than 40 million people will be infected with the human immunodeficiency virus ... up from 13 million people now" [reported in *The Wall Street Journal*, June 4, 1992].

A recent study published by the Centers for Disease Control shows that AIDS in the U.S. is continuing to spread rapidly among women and among heterosexual men who inject drugs.

As reported in *The Wall Street Journal* [July 3, 1992], cases increased 9.8% in these two groups between 1990 and 1991 (to 11,155) and accounted for nearly one-quarter of all U.S. reported cases.

In total, there were 45,506 AIDS cases reported in 1991, up 5% from 1990. The number of new cases among homosexual men actually decreased slightly (0.4%) to 23,960 in 1991. Among Hispanics there was an 11.5% increase and a 10.2% increase among blacks. Geographically, the South reported the largest increase last year, a 10.2% jump to 15,761 cases.

An article appearing in the magazine *America* claims, "Among minorities in general, IV drug use accounts for the fastest growing group of persons with AIDS. ...80 percent of all people with AIDS who reported a history of IV drug abuse are minorities. Many are women." [July 13, 1991, "Drug Treatment and The Poor" by George M. Anderson]. The author asserts that in 1990 Hispanics were disproportionately likely to have AIDS in that they comprised 16% of all cases and only 9% of the U.S. population. Almost half the Hispanic cases involved IVDUs; compared to the white population in which only one in seven AIDS patients was an IVDU.

Growing concern has also focused on teenagers. Recently, Chicago launched a 5-year, $1.5 million federally funded HIV Adolescent Risk Reduction Program. As reported in the *Chicago Tribune* [May 2, 1992], primary emphasis will be on education and condom distribution, with a focus on heterosexual relationships. But it was noted that nationwide "there are seven times as many cases of AIDS among youths due to gay sex and intravenous drug use as there has been due to heterosexual sex." As of February 1992, of 9,210 total U.S. cases among youths 13 through 24, 4,788 were attributed to homosexual sex and 2,325 (25%) to intravenous drug use.

Chicago, San Francisco, Boulder, Colorado and New York embarked on a controversial clean needle exchange research program this summer to determine the effectiveness of such approaches in reducing the spread of HIV among IVDUs. The Chicago Recovery Alliance received a $65,000 grant from the Washington-based American Foundation for Aids Research for the program, according to the *Chicago Tribune* [May 16, 1992]. It is estimated that there are 60,000 to 80,000

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intravenous drug users in Chicago, with about 28% infected with HIV.

Illinois law prohibits possession of a hypodermic needle without a prescription, but the law exempts people who are engaged in research. Although California has laws similar to Illinois, the San Francisco Health Department is part of the study. The New York State Health Department exempted the research project from needle laws for two years. Colorado law permits needle exchanges.

Meanwhile, disagreements over clean needle programs and interim methadone clinics were two key issues in delaying a long-awaited bill to reorganize the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). According to *Substance Abuse Report* [June 15, 1992], many congressmen, as well as the Bush administration, oppose clean needle programs on the grounds that there is no evidence that they reduce incidences of HIV infection and may only encourage further drug use.

Two years ago the federal government dropped interim methadone proposals in response to treatment providers who argued methadone should only be given as part of a more comprehensive approach including testing and counseling. Originally, interim methadone was viewed as an anti-AIDS measure, assuming heroin addicts wouldn't inject or share needles if they could have ready access to methadone. A major opponent of interim methadone, Rep. Charles Rangel (D-New York) stated, "...nowhere have I found that using methadone by itself as a treatment modality should be accepted." May 28 on the House floor, he claimed, "...state agencies say that if they cannot provide full service, they should not be giving this very dangerous drug called methadone."

The ADAMHA Reorganization Act (S. 1306) was finally passed and enacted on July 1, 1992. Use of federal funds for interim methadone maintenance was approved. However, clean needle programs were not passed as part of the bill.

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...Patient's Perspective:

"especially because I expected more from medically trained personnel." Neither her private physician nor dentist knows of her methadone patient status.

Regarding efforts to make methadone more diversion proof, Doris believes "methadone will continue to be diverted as long as there is a market, i.e., so many addicts waiting for treatment." She'd prefer seeing resources directed to treating all those who need it. "Apparently, the recent rise in illicit sales of methadone by MMTP patients has caused the staff to become that much more conservative in granting [increased] take home medication which is unfairly punitive," she claims.

Doris writes, "Detoxification is problematic due to the fact that each of my experiences has been painful, frightening and ultimately discouraging. There is certainly inadequate information about and procedures for detoxification. I will not seek detoxification again until I have enough resources to overcome the pain; enough courage to overcome the fear and enough faith to overcome the odds."

A.T.F.

News Note...

New Coalition Seeks Shift Toward Drug Treatment

A 58-group coalition, led by Rep. John Conyers (D-Michigan), seeks to change the focus of current White House drug strategy. As reported in *Substance Abuse Report* [June 15, 1992], they want to emphasize treatment rather than law enforcement with at least a 50-50 split between enforcement and treatment/prevention. Currently, 70% of federal anti-drug funds go for enforcement.

Conyers is quoted as saying, "It is time to turn around our emphasis on a law enforcement approach at home and abroad, and replace it with education, treatment, prevention and job training. Two different drug wars are being waged... [one] that targets the middle class with available treatment and accessible prevention and education, and a drug war against the inner city, where law enforcement targets low-income drug users and addicts wait three to four months for treatment."

Joining Conyers in announcing the alternative drug strategy were representatives of organized labor, parent/teacher organizations, and a who's who of associations and organizations concerned with health care and addiction issues. Conyers said he will be encouraging Congressional leaders to change their "lock-em-up-and-throw-away-the-key attitudes." He cautioned that such changes will take time and, in an election year such as this, popular opinion may reinforce a get-tough-on-crime position among candidates.

A.T.F.

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PREMIER EDITION

Research Review

Many Methadone Dosage Practices Counterproductive, Survey Finds

A national survey of MMTPs found wide variation in treatment practices across the nation. Many treatment units have practices that are not effective according to a majority of earlier studies.

The report, "Variations in Methadone Treatment Practices" [by Thomas D'Aunno, Ph.D. and Thomas E. Vaughn, M.H.A. in *JAMA*, January 8, 1992, 253-258], concluded that effective patient retention in treatment depends on adequate methadone dose levels. Yet, 25% of the 172 randomly selected units surveyed set an upper limit on dose levels of 20 to 60 mg/d. Average dose level for the majority of units (68%) was 50 mg/d or less.

The majority of units (66%) reported that their "clients" were aware of their methadone dose level, but 34% reported their patients were aware of dose level only to some, little or no extent. [Note: For unstated reasons the authors refer to addicts in treatment as "clients." However, for editorial consistency with other articles in this newsletter, the term "patients" is used unless in a direct quote from this survey. Ed.]

The survey discovered that 50% of the units encourage patients to detoxify in less than 6 months, and most units (54%) have an average treatment length of 20 months or less per patient.

One conclusion stated by the authors is: "To the extent that high dose levels and client participation in dose decisions contribute to client retention in treatment and abstinence from illicit narcotics drug use, the data suggest that the practices of many units are counterproductive."

Several correlations were revealed by the study:

- Those units with higher upper limits on dose levels were more likely to allow take-home dosages, and to have patients aware of and participate in influencing dosage level.
- Conversely, units with more patients receiving decreasing dose levels were less likely to have patients aware of dosage, encouraged patients to detoxify sooner, and had shorter patient time in treatment.
- Units that treated a higher percentage of black patients had lower limits on dose levels, had lower average dose levels, and were less likely to permit take-home dosages.
- Units that treated a higher percentage of younger patients were less likely to have patients aware of dose levels and had lower limits on dose levels.
- Units with more unemployed patients were less likely to have patients aware of dose levels, and were more likely to encourage early detoxification.

The authors noted that, "Length of time in treatment is critical; results from several studies indicate that time in treatment is the strongest predictor of treatment success." In their survey, units with higher average dose levels

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