ADDICTION TREATMENT

Forum

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An emerging life or death issue is refusal to treat liver disorders in MMT patients or to allow them on transplant waiting lists.

IN THIS ISSUE

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Liver Disease in MMT: Treatment & Transplant

Part 1: Critical Concerns

The epidemic of liver disease in methadone maintenance treatment (MMT) programs, lurking like a massive iceberg with only its tip exposed to public view, has been noted before in *AT Forum*.[1,2]

Former intravenous (IV) drug addicted persons may harbor several types of hepatitis: A, B, C, and D. Hepatitis C (HCV) is perhaps the greatest threat, since most persons who contract it go on to develop chronic illness. Liver failure due to HCV results in up to 10,000 deaths annually in the United States and is the leading cause of liver transplantation nationwide.[3]

An emerging life or death issue is refusal on the parts of many medical specialists to treat liver disorders in MMT patients and/or to allow those patients on transplant waiting lists. A critical focal point of this controversy is methadone itself.[4,5]

Medical, ethical, legal, and economic concerns have arisen. This article is the first in a series focusing on those issues and on some possible action steps.

Prevalent Threat

Hepatitis C (HCV) is a blood-borne virus affecting approximately 4 million Americans, the majority being past or present illicit IV-drug users. This group represents the greatest proportion of new infections each year and the largest pool of persons eventually needing liver transplantation.[6]

HCV causes inflammation of the liver that can lead to scarring and failing liver function. At later stages, HCV can cause cirrhosis, in which the liver is

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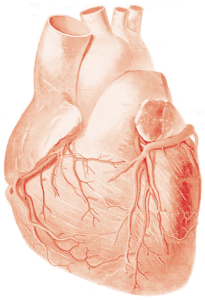
Clinical Concepts

Cardiovascular Health in MMT Patients

*By Mori J. Krantz, MD**



According to current estimates nearly 61 million Americans have one or more types of cardiovascular disease, including coronary artery disease (CAD), congestive heart failure, and hypertension.[1] Methadone maintenance treatment (MMT) patients are clearly part of this larger demographic, and there are unique clinical characteristics in this group warranting special attention.

High Risk, Less Access

Patients entering MMT are a very high-risk population from a general health maintenance standpoint. As a rule, patients who use illicit drugs expose themselves to a number of health risks, and are less likely to regularly interface with the healthcare system. An increased reliance on emergency services and a lack of integration into healthcare delivery systems create a backdrop for poor outcomes.

The literature confirms that barriers to high quality care for cardiovascular disease are greater in vulnerable patient populations, such as minorities and the poor. A great many MMT patients fall into both of those categories.

For example, African Americans and low-income patients are less likely to receive care by a cardiologist. In con-

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Events to Note

For additional postings & information, see: www.atforum.com

JANUARY 2002

3rd Annual Juvenile & Family Drug Court Training Conference
January 24-26, 2002
Ascuaga's Nugget Hotel; Reno, Nevada
Contact: 703-706-0576

FEBRUARY 2002

International Conference on Addictions (Council on Substance Abuse - NCADD)
February 10-11, 2002
Civic Center, Montgomery, Alabama
Contact: 334-262-1629; www.cosancadd.org

Summit for Clinical Excellence (Ben Franklin Institute)
February 21-24, 2002
Savannah, Georgia
Contact: 408-563-1192; info@benfranklininstitute.com

MARCH 2002

Behavioral Health International Conference (Sponsored by CARF)
March 16-19, 2002
Marriott Univ. Park Hotel; Tucson, Arizona
Contact: 520-318-1129; bmcmuldren@carf.org

National Conference on Co-Occurring Disorders
March 27-29, 2002
Westin La Cantera; San Antonio, Texas
Contact: 888-869-9230 or 615-742-1000

APRIL 2002

ASAM 33rd Annual Meeting & Scientific Conference
April 25-28, 2002
Hilton Atlanta, Atlanta, Georgia
Contact: 301-656-3920; www.asam.org

COMING LATER...

NADCP 8th Annual Training Conference
June 13-15, 2002
Marriott Wardman Park; Washington, DC
Contact: 703-706-0576; Fax: 703-706-0577

NAADAC 26th Annual Conference on Addiction Treatment
July 3-6, 2002
Marriott Copley Place; Boston, Mass.
Contact: 800-548-0497 or 703-741-7686

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

A.T.F.

Straight Talk... from the Editor

New Visions for the 21st Century

Despite tragic events of last September and concerns about travel, more than 1,200 persons representing 15 countries gathered in St. Louis, Missouri on October 7-10, 2001 for the American Methadone Treatment Association (AMTA) Conference.

There were an unprecedented 10 pre-Conference sessions, followed by 39 workshops and hot-topic sessions, along with 35 exhibits and 27 poster presentations. A plenary session on each day of the conference featured distinguished speakers addressing the theme "Opioid Treatment in the 21st Century: Implementing the Vision." Here are some highlights.

AMTA Now AATOD

Association President, Mark Parrino, MPA, stressed, "We are probably in the midst of the most profound and dynamic changes since the implementation of MMT." The field is now supported by pure science, undeniably defining how methadone works and its value.

He asserted that it is time to become more involved in mainstream medicine and in the criminal justice system. There also is a need to embrace pharmacologic alternatives for opioid addiction treatment, such as buprenorphine, which can augment, but not replace, methadone therapy.

In view of those broad objectives, AMTA is changing its name to the American Association for the Treatment of Opioid Dependence (AATOD).

5-Year Plan Released

Parrino discussed the Association's 10-point, 5-year plan for methadone maintenance treatment (MMT) in the United States. The starting point is supporting improvements in the quality of MMT services through accreditation. Furthermore, it is necessary to increase treatment referrals through drug courts, probation departments, and prisons.

Training and education are also prominent in the plan. The Association will continue physician, clinic management, and program staff training via conferences, symposia, and on-site offerings or distance-learning initiatives. Furthermore, educating the American public about the value of MMT is an ongoing priority and essential for future success, Parrino noted.

There is plenty of room for AATOD growth in coming years, as only 19 of 42 states with MMT programs are Association members; although, this represents more than 80% of methadone programs in the U.S. An aggressive initiative has been launched to recruit individual MMT providers in non-member states, which also may lead to formation of new statewide associations.

Accreditation Accelerating

Continuing the discussion of critical changes, H. Westley Clark, MD, JD, MPH, Director, Center for Substance Abuse Treatment (CSAT), commented that the new rule regarding MMT program accreditation went into effect last May. During the Conference, CSAT sponsored several special seminars addressing accreditation issues, and Clark offered that persons with questions should call 1-866-463-6687 or visit www.opat.samhsa.gov.

In the course of the initial testing phase, 94% of programs evaluated by CARF received 1- to 3-year accreditation and 86% of JCAHO-evaluated programs received 3-year accreditation. Others were granted more provisional accreditation and only three programs failed entirely.

Clark said a study on the impact of the accreditation process is to be completed by the summer of 2002. He projected that there will be a 3% growth rate in MMT programs during coming years.

Buprenorphine/LAAM in Limbo

As for alternative opioid agonist medications, Clark mentioned that buprenorphine and the buprenorphine/naloxone combination are still under review by the FDA. He speculated that these agents might be approved by early 2002, but it would take another several months before they are in distribution. The eventual cost of the drugs is still unknown.

Meanwhile, Clark observed, there has been ongoing training of physicians in how to use buprenorphine. He expects there will be 2,000 physicians qualified as prescribers by the end of this year.

Will buprenorphine replace methadone?

"No," according to Laura McNicholas, MD, Director of CESATE, University of Pennsylvania, who presented a special

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pre-Conference session on buprenorphine clinical guidelines. Despite certain distinct advantages of buprenorphine in some patient populations, there also are some limitations.

For one thing, the maximum effective dose of buprenorphine is equivalent to only about 60 mg/day of methadone. Patients requiring higher opioid agonist doses, such as those with longer-term or more recalcitrant opioid dependencies, might not fare as well on buprenorphine.

Furthermore, the buprenorphine/naloxone combination is not appropriate for use during pregnancy, since effects on the fetus are unknown. And, there could be difficulties in patients needing chronic pain management, since there is a ceiling effect of buprenorphine and it also blocks other opioid medications.

Regarding LAAM, Clark commented that, according to new FDA labeling, the agent is now recommended for use only in patients who have failed other treatment modalities. There has been a reported "low frequency potential for fatal outcomes" due to cardiac complications with LAAM, he said, and there are still questions regarding its safe use.

During the Conference it was announced that Roxane Laboratories was seeking a buyer for the marketing rights to its LAAM product, Orlaam®. According to some sources, further clinical evaluations of LAAM's safety were requested by the FDA, and discussions were underway with the National Institute on Drug Abuse (NIDA) regarding assistance in funding those trials.

"Stabilization Therapy"

In his always entertaining though informative style, Alan Leshner, PhD, Director of the National Institute on Drug Abuse (NIDA), stressed that a new discourse is needed in the addiction treatment field – one that stops polarizing the issues.

"What matters most in addiction is compulsion," he said. Particular distinctions between physical and psychological, or biological and behavioral, factors are less important.

Prolonged drug use changes the brain in ways that engender compulsion and interfere with behavior. The fact is that drug dependent persons just can't say "no" and quit. Substances of abuse usurp normal intrinsic motivational systems in the brain and provide greater rewards than anything else in life. For example, research has demonstrated that cocaine can provoke a greater response in the brain of an addicted person than sex.

Methadone might be more aptly called "stabilization therapy" to overcome the stigmatizing myth that it is merely substituting one opioid with another.

However, according to new research, Leshner observed, the brain of a drug-abstinent person can recover over time. Unfortunately, it can take a long time.

Medications can help stabilize brain chemistry during recovery. Leshner suggested that methadone might be more aptly called "stabilization therapy" to overcome the stigmatizing myth that it is merely substituting one opioid with another.

He further declared that the time has come to do away with simplistic metaphors. For example, the "War on Drugs" is meaningless as a slogan: it has been taken the wrong way and has lost its true focus. The ultimate strategies for dealing with drugs in America have to be as complex as the problems themselves, and science enables us to address those complexities in understandable ways.

Also, he continued, addiction treatment does not have to be voluntary to be effective – treatment while in the criminal justice system works very well. Although, he conceded, treatments usually offered in the criminal justice system are too restrictive and often erect barriers to the use of medications such as methadone.

[After the Conference, it was announced that Dr. Leshner would be leaving his post at NIDA, effective December 2001.]

Views From The Bench

Addressing the integration of MMT services into the criminal justice system, Peggy Fulton Hora, Judge of the Superior Court of Alameda County (Haywood) California observed that the "brain disease" model of addiction described by Leshner greatly appeals to judges, since it is science based. She believes judges are very receptive to scientific evidence if it is properly presented.

Judge Hora acknowledged that there has been antagonism toward methadone by judges and prosecuting attorneys in the past. She proposed, however, that the time is right for change and this will come via greater interaction between the judicial and treatment communities. Changing just one judge's mind can benefit thousands of people, she suggested.

A national agenda is needed to provide methadone in jails and prisons, Hora continued. In that regard, correctional facilities need methadone treatment protocols. This has been accomplished in California, she observed, where methadone is allowed in jails if it is verified that the inmate was previously in an MMT program.

Jeri B. Cohen, Circuit Court Judge, Dade County (Miami) Florida, concurred that methadone's efficacy has been established, yet drug court judges often disapprove of the modality. To overcome this, MMT providers need to reach out to the judicial system and, if necessary, go into court with patients to explain why those persons need to be on methadone.

In her own case, as a family court judge, Cohen expressed frustration at the lack of cooperation from and among local addiction treatment providers. She is often faced with separating children from their heroin-addicted parents because local drug-treatment programs prohibit methadone therapy.

These fathers or mothers were unable to withdraw from opioids and dropped out of treatment or died, leaving their children behind, she said. Meanwhile, MMT providers in her jurisdiction have remained silent, Cohen lamented, as she exhorted the audience to become more involved in the justice system.

Doing Our Parts

During the closing session, Edward H. Jurith, Acting Director, Office of National Drug Control Policy (ONDCP), Washington, DC, observed that the Bush administration is committed to drug treatment and supports MMT. This is evidenced by the nomination of Andrea Barthwell, MD, a member of the AMTA Board of Directors, to be Deputy Director of ONDCP for Demand Reduction.

Five-million persons are in need of drug treatment, yet only a fraction receive it, Jurith noted. President Bush has asked for $1.65 billion over the next five years to close that gap.

"We're thinking of how we can better integrate resources of the drug treatment system into the criminal justice system,"

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he continued. We now have more than 1,050 drug courts in this country, compared with only 10 in 1991, and there are plans to increase this system.

"We have taken the treatment debate out of the political realm and put it in the public health arena where it belongs. We know more about drug abuse and how it works in the brain, and how to treat it, and how to prevent it than at any other time in our history," Jurith concluded. "We need to be more aggressive in putting that knowledge into practice. We all have our parts to do."

Nation's Capitol Next

Reserve April 13-16, 2003 on your long-range calendar for the next AATOD (formerly AMTA) Conference, which will be in Washington, DC. Plan to bring the whole family.

Survey – Liver Disease in MMT Patients

As a follow-up to our article in this edition on Liver Disease in MMT Patients, we want to survey our readers' experiences. Please respond to the following questions:

1. Do you know of patients who were denied treatment for hepatitis C because they were on methadone?
____no; ___ yes. If yes, how many? ____

2. Do you know of patients who were denied a liver transplant because they were on methadone?
____no; ___ yes. If yes, how many? ____

3. Do you know of MMT patients who died because they could not get treatment or a transplant for their liver disease?
____no; ___ yes. If yes, how many? ____

There are several ways to respond: **A.** Provide your answers on the postage-free feedback card in this issue; **B.** Write or fax us [see info below], or; **C.** Visit our Web site to respond online. As always, your ***written comments*** are important for helping us discuss the results in an upcoming issue.

Stewart B. Leavitt, PhD, Editor
stew202@aol.com

Addiction Treatment Forum
P.O. Box 685
Mundelein, IL 60060
Phone/Fax: 847-392-3937
Internet: http://www.atforum.com

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trast, white race, higher income, and college education independently predict care by a cardiologist.[2]

Available data suggest that the gap in cardiovascular disease mortality between the poor and uneducated versus the wealthy and well educated has not lessened and may be widening. The National Conference on Cardiovascular Disease Prevention concluded that to attain the goals set forth by the U.S. Surgeon General's Healthy People 2010 initiative, we should focus on reducing disparities in health status on the basis of race, ethnicity, and socioeconomic status.[3]

... from a cardiovascular perspective, methadone is a safe medication and MMT program staff can perform vital roles in providing effective cardiac risk reduction services.

To make matters worse, mainstream physicians often stigmatize MMT patients. This further distances these patients from regular, preventive health care services.

Some Specific Cardiac Risks

Endocarditis

Intravenous drug users (IVDUs) are at high risk for developing infections of their heart valves (infective endocarditis). These infections are a direct result of bacteria entering the bloodstream at the skin site of injection.

Acute infection accounts for the majority of hospital admissions among IVDUs and endocarditis is found in 10% of these episodes.[4] Most of these patients have no pre-existing cardiovascular disease.

The symptoms of this disorder may include persistent fever, chills, sweats, muscle and joint aches, malaise, and back pain.[5] These symptoms are invariably preceded by an episode of intravenous drug use.

Endocarditis has very high morbidity and mortality. It can necessitate extended intravenous antibiotic therapy and in many patients will require complex heart valve surgery or even valve replacement. Other consequences of endocarditis include brain abscess, kidney failure, and death.

MMT offers substantial protection from this deadly disease by eliminating or dramatically reducing the amount of illicit drug use. In our local hospital experience during 2000-2001, practically none of the heroin-abusing patients admitted with endocarditis were in methadone treatment programs.

Furthermore, in my oversight of hundreds of MMT patients during nearly a decade, I have encountered only 3 cases of endocarditis in that population. This evidence is anecdotal and retrospective, but supports the common sense notion that methadone treatment dramatically reduces the risk of endocarditis in IVDUs.

Coronary Artery Disease (CAD)

CAD is the number one cause of death in the Western world [1] and MMT patients are no exception. These patients may be at particularly high risk given that as many as 90% of them smoke tobacco, which is a known risk factor for CAD.[6]

Additionally, cocaine abuse is seen with some frequency in this population. Cocaine use has been linked to the development of arrhythmias, CAD, heart attack, and death.[7]

Despite the uses of tobacco and cocaine in MMT patients there have been no published reports documenting a higher overall incidence of cardiovascular disease in these patients. In my MMT practice, there are very few patients with established CAD. This is remarkable, given the fact that a significant proportion are beyond 50 years of age and many continue to smoke cigarettes.

Is there a possible explanation for this relatively low incidence of CAD in MMT patients?

The evidence is not clear. However, there is some pharmacologic data suggesting that methadone may exert a calcium channel blocking effect.[8] Calcium channel-blocking medications lead to slower heart rates and reduced cardiac work, and these agents are effectively used to treat CAD patients who develop symptoms of angina (chest pain).[9]

Also, opiates, including methadone, are known to reduce blood pressure and slow the heart rate. Morphine, for instance, is a commonly used medication to treat hospitalized patients who experience a heart attack.

Thus, due to these properties, methadone is theoretically protective in

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preventing or reducing cardiac ischemia (lack of blood supply to the heart).

Cardiac Arrhythmias

There is no compelling evidence in the literature to suggest that methadone treatment is a direct cause of sudden cardiac death or fatal heart rhythm disturbances.

In clinical practice, the risk of cardiac arrhythmias attributable to these treatments currently appears to be quite small. Future research and accurate incidence data will help clarify any contribution of opioid-agonist therapies to arrhythmia risk.

MMT Minimizes Cardiac Risks

Ongoing participation in MMT affords patients many heart health benefits. For one thing, these patients have significantly greater access to preventive cardiac-health services than opioid-dependent persons not in treatment.

MMT patients are provided periodic monitoring of their blood pressure and pulse. Vital signs are obtained upon admission, during yearly physical exams, and during dose changes.

In my experience, this has offered a tremendous opportunity to screen patients for hypertension and then provide adequate treatment. Hypertension afflicts 50 million Americans; it is a leading contributor to CAD and the number one cause of stroke.

In my practice, a full lipid panel is obtained annually in all patients to check cholesterol levels. Those with elevated levels can be offered effective treatment with cholesterol-lowering medications, which have clearly been shown to reduce the risk of heart attack and death in patients who are at high risk.[10-12]

Finally, patients in MMT have access to frequent professional counseling, which presents ideal opportunities for discussing the importance of smoking cessation for long term cardiac health. The most common cause of death in smokers is coronary artery disease (CAD).

Stopping smoking dramatically reduces the risk of future heart attack or death. We regularly counsel patients on tobacco risks and many are able to quit or significantly reduce tobacco consumption as part of comprehensive treatment plans. In conclusion, from a cardiovascular perspective, methadone is a safe medication and MMT program staff can perform vital roles in providing effective cardiac risk-reduction services.

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*__Mori Krantz, MD__ is Director of the Cardiovascular Risk Reduction Program, Denver Health Medical Center, and Assistant Professor of Medicine and Cardiology, University of Colorado.

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scarred throughout and there is the risk of complete liver failure (end-stage liver disease).

Based on a synthesis of statistics reported in the literature,[6-9] roughly 90 of every 100 injection-drug users entering MMT programs are likely to be infected with HCV. Only 14 of those patients will recover from HCV on their own; the remaining 76 will probably develop chronic disease unless they receive successful treatment. There is no way of predicting who will recover without treatment.

Even with treatment, about 17 of those initial 100 MMT patients will go on to develop cirrhosis and 8 will require a liver transplant for survival. Although treatments for HCV have been improving, there could be as many as 14,000 current MMT patients in America eventually needing liver transplants.

From Bad to Worse

Unfortunately, last year there were only about 5,000 liver transplants performed in 122 transplant centers across the U.S. As of September 2001, there were nearly 18,500 persons on waiting lists for liver transplants.[10] So, in the best of circumstances, less than a third of those on wait-lists receive new livers.

Since 1988, only an estimated 180 MMT patients have had liver transplants; less than 0.5% of the 40,468 procedures performed. Today, there are merely an estimated 102 MMT patients on waiting lists, or 0.6% of the total.[11]

Making matters worse, the MMT population is aging. Many patients who contracted HCV years ago are at stages in their illness where treatment or transplant is a do or die situation.

A majority of illicit IV-drug users with HCV may be coinfected with HIV, which greatly accelerates the devastation of HCV. As an emerging problem, coinfected persons are facing insurmountable obstacles to treatment or transplant for their liver disease.[8] Furthermore, many MMT patients also use excessive alcohol, which compounds cirrhosis and related complications in those with HCV.[9]

Treatment Barriers

Tragically, there has been an irrational withholding or delaying of available treatments for hepatitis in MMT patients and/or their rejection by liver transplant programs.

On the basis of recommended guide-

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lines from consensus conferences held in the United States, Canada, and Europe, most specialists refuse to administer antiviral HCV treatment until all illicit-drug use has ceased for a period of time – usually 6 months. Some practitioners also require abstinence from methadone.

In actuality, these guidelines provided little explanation or justification for those practices, have been largely misinterpreted, and say nothing about methadone.[3,9]

A more recent guideline on HCV management from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) specifically states, "Patients can be successfully treated while on methadone."[12] This message has been largely overlooked by liver treatment specialists.

According to Diana Sylvestre, MD – Executive Director of O.A.S.I.S.-Abuse (Organization to Achieve Solutions in Substance Abuse) in Oakland, California – the most serious impediment may be stigma, prejudice, and misinformation surrounding addiction and MMT. Her nonprofit clinic specializes in serving patients with HCV, particularly referrals from MMT clinics, in the San Francisco Bay Area.

"A physician can state a lot of reasons for not treating HCV in MMT patients," she says, "but it often comes down to prejudice. Superficially, the reason usually seems justifiable, since there are so many potential barriers to treating HCV in MMT patients that a rationale can usually be derived for denial of treatment."

Critical Timing

In general, some authors have noted that up to 36% of all HCV-infected patients never receive antiviral treatment,[9] and this proportion is greater in addiction treatment populations. Sylvestre observes that, of approximately 850 HCV-diagnosed patients seen at her clinic, only 100 have received treatment to date.

Treatment is legitimately delayed in some patients because they have active psychiatric disease, an unstable family or job situation, or a medical condition needing more immediate attention. However, Sylvestre works closely with these patients to remove the barriers to successful HCV treatment.

It also has been suggested that patients at very early stages of HCV may not benefit from treating the disease.

There is no scientific evidence to support discontinuing methadone as a requirement for liver transplantation.

However, a new study from Germany reported that the HCV virus became undetectable in 98% of patients treated within 3-months of becoming infected.[13]

Sylvestre points out that it is very difficult to identify acute HCV infections in opioid-addicted persons, since at the time of infection they are rarely attending to their medical needs. Furthermore, her experience has been that if the person is still injecting illicit drugs there will be extremely poor response, if any, to antiviral treatment for HCV.

Transplant Obstacles

With transplantable livers in such short supply, transplant programs jealously guard each place on their waiting lists. Only those candidates considered most likely to achieve long-term survival with a new liver are selected.

Many liver transplant centers, while claiming to evaluate patients on an individual basis, will consider only those MMT patients who withdraw from methadone.

Relatively recent survey results, encompassing 90% of liver transplant programs, depict severe discrimination against patients taking methadone.[11] The authors found that 44% of the programs denied acceptance of MMT patients on their waiting lists and nearly a third of those that did accept MMT patients required withdrawal from methadone. Essentially, 62% of liver transplant programs prohibited methadone in one way or another.

Sylvestre referred a male MMT patient with advanced cirrhosis to a major west coast transplant center for evaluation. They insisted he first withdraw from methadone, although the patient was otherwise qualified for a transplant.

Due to the stress of withdrawal the man experienced upper gastrointestinal complications, including bleeding esophageal varices. The man continued methadone withdrawal to receive a liver transplant and eventually died from a variceal bleeding crisis.

Ellen Weber, JD, Senior Vice President of the Legal Action Center (LAC) in Washington DC, tells of a female MMT patient who was listed for a liver transplant at a center in Maryland. However, when she moved to Florida, the local transplant center refused to even evaluate the woman as long as she was on methadone. The woman chose to remain in MMT and her liver disease has progressed to the point that she is currently in a nursing home.

Catch-22s

To date, there has been very little research on liver transplant outcomes in opioid-dependent persons or those maintained on methadone.[3] In particular, there is no scientific evidence to support discontinuing methadone as a requirement for liver transplantation.[11] In catch-22 fashion, such a requirement may induce relapse in formerly stable patients and, because of this, would disqualify them from transplant.

Another absurdity, described by Sylvestre, is that the California Medicaid program – Medi-Cal – will pay for medications and office visits if the person has a recognized disability. Unfortunately, the criteria for being classified as disabled on the basis of HCV requires evidence of decompensated (very severe) liver disease that, under most circumstances, precludes treatment with medication; a transplant would be needed. This results in a very large population with treatable HCV in her clinic that does not qualify for financial assistance.

In one case, Sylvestre was successful in getting a patient wait-listed for a liver at an enlightened transplant center. However, Medi-Cal authorities insisted that the patient withdraw from methadone before transplant. She says those authorities have not been able to provide any medical rationale for this requirement.

Legal Pursuits

Is there a remedy in law?

The LAC's Weber comments that Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability by institutions receiving federal financial assistance. To the extent that transplant centers are denying patients the opportunity to be considered for transplant on the basis of past addiction problems requiring methadone ther-

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Where to Get Info

Video Depicts Addiction/MMT Story

METHADONE TREATMENT: The Hope for a New Life is a 30-minute videotape providing critical information on opioid addiction and methadone maintenance treatment (MMT). Produced by COMPA (Committee of Methadone Program Administrators, Inc.) of New York State, it depicts the true story of opioid addiction, including the disease process and its devastating effects on the addicted person, the family, and the community.

On camera testimony of experts in the field and patients clearly underscore the overwhelming efficacy of MMT. Viewers will find the video compelling and enlightening, providing new insights into addiction and methadone treatment that are certain to dispel myths and help overcome stigma.

The video normally costs $90. However, it is being made available to *AT Forum* readers for **only $45 plus $5 shipping and handling** (be sure to mention *AT Forum* when ordering). Contact COMPA at: 250 Fifth Ave, Suite 210; New York, NY 10001. Phone: 518-281-8965; fax: 518-426-1046.

Methadone Primer for Patients

About Methadone is a 50-page booklet from the Lindesmith Center-Drug Policy Foundation that covers most of the questions patients and their loved ones might have about methadone maintenance treatment. Written in nontechnical language, it gives facts, dispels myths, and also provides helpful tips on such topics as traveling with methadone, storing the drug, concerns about overdose, and much more.

To obtain copies, contact the Lindesmith Center at 212-548-0695; methadone@drugpolicy, or visit www.drugpolicy.org.

Advocacy Newsletter Resurrected

NAMA Advocate is the latest incarnation of the National Alliance of Methadone Advocates' newsletter. This publication reports on diverse issues pertaining to methadone and other subjects of interest to patients in MMT programs. Clinic staff will find this publication worthwhile reading to keep informed of events on the advocacy front.

Available online at www.NAMAnews.com. To join NAMA and receive the print edition contact: 212-595-NAMA; or visit www.methadone.org.

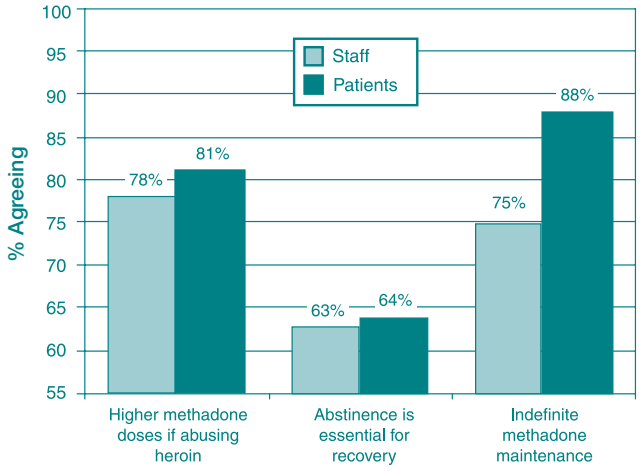
A.T.F.

Reader Survey - MMT Attitudes

The Spring 2001 edition of AT Forum (Vol. 10, No. 2) surveyed reader attitudes regarding methadone maintenance treatment (MMT). Responses expressed agreement or disagreement with the following three statements:

1. An MMT patient who continues to use heroin should be given higher doses of methadone.
2. Complete abstinence from illicit drugs is essential for recovery in MMT.
3. Many patients need to be maintained on methadone indefinitely.

There were 430 respondents (280 staff; 150 patients).



Abstinence Orientation

Disagreement with the first and third statements, and agreement with the second, might characterize what has been called an "abstinence orientation." This was first discussed in *AT Forum* about 5 years ago (Fall 1996, Vol. 5, No. 3), referring to research by John Caplehorn, MD and colleagues.

Their research found that abstinence-oriented clinic policies were closely tied to suboptimal methadone doses, zero tolerance for illicit drug use, and negative views of long-term methadone. It was suggested that such policies, grounded in underlying attitudes that are somewhat anti-methadone, adversely affect treatment outcomes.

This present *AT Forum* survey suggests that an abstinence orientation persists among many staff members and, surprisingly, in a sizable proportion of patients. Among staff, 22% and 25% disagreed with statements 1 and 2, respectively; 63% agreed with statement 2. See **graph**.

Increase Methadone Dose?

Staff and patients appeared to have similar views (80% on average) regarding the benefit of increasing methadone dose if a person continues to abuse heroin. However, it would be interesting to know how the 20% disagreeing with statement number 1 might handle seemingly recalcitrant patients.

One patient wrote that he has been in MMT for more than 24 years, and believes he is a "model" patient who owes his life to methadone. Yet, he admitted that every 2 or 3 years he has used illicit drugs: "There is simply no compulsion or desire to do so more often."

Another patient noted that she was prescribed 30 to 40 mg/day of methadone for years and continued using heroin. "It wasn't until I was given a substantial increase due to positive urine screens and a pregnancy that a miracle happened," she wrote. "I stopped using."

Abstinence?

On average, 64% of patients and staff agreed that abstinence was essential for recovery.

One staff member who disagreed, thus reflecting less of an abstinence orientation, commented that complete abstinence from illicit drugs is a goal that may take some time as the patient deals with obstacles to recovery.

A patient noted that just because a person "slips up" once in a while does not mean that they have failed. It should not affect their recovery overall.

Lifetime Methadone?

Reflecting abstinence-oriented disagreement with the third statement, one clinic medical director stated that, while many patients may want to stay on methadone indefinitely, he believed that very few needed it for a lifetime.

Many patients who disagreed with indefinite MMT expressed frustration with their clinics and the stigma surrounding methadone. However, other approaches, such as medical maintenance away from less flexible clinic settings, could make lifelong methadone therapy much more appealing to stabilized patients.

Finally, a staff member, whose responses indicated a strong abstinence orientation, suggested that methadone is only one tool among many to increase the potential for recovery, and it may not be the best tool. As is sometimes the case, there is a question as to why this person would want to work in an MMT clinic.

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apy, a legal challenge can be filed in court or with the Department of Health and Human Services (DHHS) Office of Civil Rights.

To refute discrimination claims, healthcare institutions must demonstrate a scientific or medical rationale for the denial of services. This same principle applies to individual medical practices under the Americans with Disabilities Act – treatment cannot be denied solely on the basis of methadone use, unless scientific or medical data exists to support that standard of care.

Weber believes a "Guidance" from DHHS on Section 504 nondiscrimination requirements in the delivery of health services would clarify issues relating to HCV treatment and transplant in MMT patients. Development of this could take time.

Meanwhile, Weber has made a start and is gathering information on individual cases. Regrettably, the LAC's efforts have been hampered by a lack of funding to more actively pursue these issues.

The LAC, with offices in Washington and New York, has focused for the past 28 years on protecting individual rights and expanding access to treatment for persons with drug problems and AIDS, among others, at no charge to clients.

A Role for MMT Clinics

Sylvestre believes MMT programs can be more proactive. Programs need to become educated on HCV-treatment criteria and the barriers to treatment so they can make appropriate referrals.

If MMT programs make inappropriate referrals to liver specialists in the community, that referral base will disappear. "It doesn't do any good to send a homeless MMT patient who is actively psychotic and has little potential for successful outcomes to a hepatologist," she says.

Programs also should become advocates for their patients needing treatment. She finds that those programs that are knowledgeable and have earned patients' trust are most successful in getting them into HCV treatment. MMT staff then need to be proactive in helping HCV-treatment providers manage these patients throughout the course of treatment.

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Into Action:
CSAT's Office of Pharmacologic & Alternative Therapies (OPAT) is developing an evidence-based research monograph supporting treatment/transplant in MMT patients with liver disease. This will be distributed to liver specialists and transplant centers.

Meanwhile, readers should respond to the survey in this edition of *AT Forum* on liver disease in MMT. Use the feedback card or visit www.atforum.com to reply.

Ellen Weber at the Legal Action Center is gathering specific case information regarding MMT patients who have been denied liver transplants. Contact her at 202-544-5478 or via emweber@lac-dc.org.

A.T.F.

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