Vol. II, #1

Political Perspective

What Will Clinton Mean For MMTP Programs?

Prior to the November election, Governor Clinton responded to a questionnaire from the Center on Addiction and Substance Abuse (CASA) at Columbia University. While he did not specifically deal with Methadone Maintenance Treatment issues, there are implications in the answers for this and all treatment modalities. Here are some excerpts: “I believe our nation has to find ways of treating more addicts more effectively. Further research into substance abuse and addiction... is essential for improving treatment... Federal funding of basic research is obviously constrained by budgetary considerations. Any sensible policy on drug abuse must tackle both cutting the demands for drugs and reducing supply. And I will increase the resources that are devoted to prevention and treatment. Billions have been poured into high tech surveillance and interdiction equipment, while the quantity of drugs entering the country has only increased. We have to fundamentally reexamine our interdiction policies, to ensure that resources are being used in the most efficient and cost effective way... I am proposing fundamental and far-reaching reform of America’s health care system, and treatment of drug addiction will be part of that... We will require that every insurance plan includes a core package of benefits... Treatment for drug addiction for those who need it will be incorporated in this core package along with ambulatory physician care, inpatient hospital care, prescription drugs, basic mental health

Current Comments

Women & Addiction: Why/How Are They Special?

Are there different treatment needs for women drug addicts? Are there special needs during pregnancy and thereafter for both mother and child? What is the prognosis for the children of drug addicted mothers? To begin our exploration of these very vital and complex issues, A.T. Forum interviewed Ira J. Chasnoff, M.D., President of the Chicago-based National Association for Perinatal Addiction Research and Education (NAPARE).

A.T. Forum: Dr. Chasnoff, what are some critical differences in dealing with women and drug addiction, as opposed to men?

IRA J. CHASNOFF, M.D: One of the key things you find is that women, regardless of socioeconomic status, have fewer resources than do men. This could be something as simple as transportation or as vital as child care. Often the first thing a man asks when he seeks treatment is “Where do I go?” Whereas, the first question a woman asks is, “What am I going to do with the kids?” From the work we’ve done, if someone is developing a treatment program for women, or pregnant women, it’s not going to succeed unless they can provide child

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Straight Talk... from the Editor

Policy-Makers Need To Hear A Harmonious Message

As a new Administration takes up the baton of leadership, how will policymakers respond to the chorus of voices from the addiction treatment community? Especially when there are so many tunes being sung and so much disharmony among the vocalizers.

Confusion abounds. Is addiction a medical problem, a psychological syndrome, a social issue or legal dilemma? Are addicts in treatment patients or clients?

Just considering one aspect of the broader addiction problem — the treatment of opiate addicts — we’ve heard mixed messages coming from at least three directions. First, many professionals strongly advocate various forms of drug-free treatment: psychotherapy, 28-day programs, therapeutic communities, 12-step programs, and acupuncture are several.

A second group of professionals favors pharmacologic interventions: methadone, LAAM, buprenorphine, naltrexone, clonidine, and ibogaine are but some. Many of the drugs have proven usefulness, others are still experimental.

In the case of methadone, it has been surrounded by controversy since the mid-60s when its benefits for treating opiate addicts were first demonstrated. Today, even among advocates of its use, there are disagreements about dosage levels and delivery schedules, durations of treatment, and the advantages of treatment on demand (interim methadone) versus more comprehensive care.

A third group of professionals seems to promulgate a pragmatic perspective. They admit that no single treatment modality to date has had universal success and that there are no “magic medicinal bullets” to easily zap the cycle of addiction. Acknowledging that people are different, they propose a smorgasbord of approaches to suit individual needs — whatever it takes, get the addict into ongoing treatment. The HIV/AIDS debacle, with the critical need to curtail IV drug use, has added urgency to their messages. Needle exchange programs and limited legalization of narcotics have been controversial proposals on some of their agendas.

We must emphasize that all three groups described above are well-meaning, dedicated professionals with the best interests of their addicted charges at heart. To some extent, there are research studies and clinical experiences to affirm that each group is singing the “best tune.”

Who’s the Enemy?
In contrast to the above, the roar of the law-and-order crowd may strike a simple chord for confused policy-makers: “Find the bad guys, take away their drugs, and lock ‘em up.” Maybe, that’s why in the past more funds have gone for a war on drugs — interdiction and law enforcement — than for prevention, treatment and aftercare. This, despite the fact that over the years prison cells have never succeeded in putting a lock on our nation’s drug problems.

Before addiction treatment professionals start agonizing over a new Administration not hearing your individual calls-for-action and support, consider the critical need for you to come together and present a more harmonious agenda that can be easily understood in terms of human benefits AND cost effectiveness.

"Before addiction treatment professionals agonize over a new administration, consider the need to come together and present an agenda that can be easily understood in terms of human benefits AND cost effectiveness."

As always, we welcome your viewpoints and letters. Write to us at: AT Forum, 1515 Woodfield Rd.; Suite 740; Schaumburg, IL 60173. Be certain to include a phone number where we can reach you during business hours to verify information.

Stewart B. Leavitt, Ph.D., Editor
Forum Feedback

Effective Counseling Enhances Methadone Success

[From a letter in response to the interview with Nina Peyser in the Summer 1992 A.T. Forum.]

"To argue whether addiction is a social problem or a disease is to divert attention from the real issue; it is probably both. Why does it make a difference? Because the various interests who are involved with addiction want to use the determination as an influence in getting their perspectives endorsed by those who hold the funds.

"...methadone treatment modalities, of sufficient dose and duration, have long proven to be an excellent tool in both the areas of social interest and individual support. The benefits are undeniable, while the addictive quality of methadone is the basis of all criticisms even among those who would legalize all drugs.

"The [counseling] presently given is sporadic and inadequate, in part due to the continued debate over whether addiction is a disease or behavioral disorder. It must be addressed as both...."

Constance N. Brody, Ph.D., APCE, CCDCM
Mansfield, OH

Two Patients Speak Out

"I am writing to thank you and commend you on [your] newsletter. ... I have been a MMTP patient for the past 18 years. Methadone treatment was just beginning when I started... but I never gave up or regretted being a methadone patient. I am also very thankful for the counseling and group therapy I receive at the Strong Memorial Maintenance Program. ... We have started a Methadone Anonymous program which I understand is the first of its kind."

[name withheld by editors]
Mt. Morris, NY

"I am 40 years old and have been an addict since I was 14. I've been on methadone for around 13 years, six different programs until I went to the methadone program I'm in now.

"I have been there for 5 years in group therapy and individual therapy every week. I met a counselor there that I started to listen to and my life has changed drastically. ... What I'm getting to is that it's all in the therapist... methadone programs need more caring people.

"It's about time the general public took notice and got involved, because if they don't the drug problem will not go away it will just keep snowballing."

[name withheld by editors]
Pasadena, MD

EDITORS' NOTE: To conserve space, yet present as many viewpoints as possible, feedback letters have been edited and excerpted. Original copies are on file and may be requested by interested readers [however, for confidentiality, identifying specific patients will be deleted].

A.I.F.

"Diseases" continued from back page.

people for TB. A baseline test for all patients is needed to determine if future rates of infection represent an increase or a stable situation. If an outbreak is detected, it is important to respond quickly, since the problem will only get worse with time. It is important to have a well-planned system that enables methadone programs to rapidly identify and work-up people with TB symptoms. If a methadone center can identify people who have persistent symptoms and there is a reasonable mechanism for getting them prompt chest x-rays, and sputum smears, then it can reduce transmission to its patients and workers.

[Oliver Fultz contributed to this article. For a reprint of the NEJM article, call Dr. Selwyn at 203/737-2685.]
The first one-day “Addiction Treatment Forum Symposium” was sponsored by the IADDA Methadone Treatment Committee, the BRASS Foundation and Interventions. It was funded by an educational grant from Mallinckrodt Specialty Chemicals Company, St. Louis. Chairperson Andrea Barthwell, M.D. welcomed attendees and introduced the five other speakers. Here are brief highlights:

Ed Senay, M.D. [Interventions, Chicago, IL] gave a historical perspective on methadone use, pointing out that over 150 studies to date show methadone as positive in reducing narcotic use and crime. The AIDS crisis has revitalized interest in methadone. However, Senay stressed, methadone clinics need stronger links to primary medical care and mental health systems.

Thomas Payte, M.D. [San Antonio, TX] discussed methadone dosage practices, emphasizing that dosage should be individually determined for each patient by a trained clinician. It should be based upon subjective as well as objective data and be “adequate” for the individual. Payte stressed three desired responses from methadone: prevention of the onset of abstinence syndrome for 24 hours or more; reduction or elimination of drug hunger or craving; blockade of euphoric effects of illicit narcotics.

Mark Parinino, M.P.A. [President of American Methadone Treatment Association] noted three “public relations nightmares” surrounding methadone maintenance treatment: many patients are socially disenfranchised; it is counter-intuitive to treat addiction with an addiction; and, methadone treatment is open-ended with no definite termination point. A major challenge is educating policymakers about the needs of treatment providers.

Mary Jeanne Kreek, M.D. [Rockefeller Medical Center, New York, NY] noted that in the U.S. there are 115,000 patients in methadone treatment at 720 clinics in 40 states. She observed that 50% of methadone patients will try heroin at least once during treatment, which highlights concerns about potential HIV infection. Higher doses of methadone are needed most during the first 6 months of treatment. Kreek also presented the one-year success rates of three treatment modalities: Methadone = 55-80%; Naltrexone = 15-20%; Drug Free = 20-30%.

Eldoris Mason, R.N., M.S. [President and CEO, BRASS Foundation, Chicago, IL] stressed that the addiction treatment community must attend to both the political and scientific sides of methadone treatment issues. Methadone works, but it is an adjunct to a comprehensive approach; patients need access to total health care. Much ignorance still persists about MMT. “We must educate ourselves first,” Mason asserted, “but knowledge alone never moved anyone to action.”

Andrea Barthwell, M.D. [Interventions, Chicago, IL] gave an overview of 12-step programs in addiction treatment. Two practical goals are: The ability to manage stress without drugs; the ability to be around drugs without craving. The number of 12-step meetings attended are a determinant of success. Barthwell noted that the recovery process takes at least 5 years and that the 2nd year is most critical — it’s when a defensive orientation turns to a growth orientation through “spiritual awakening.”
care right from the beginning.
A.T.F: We’ve heard that self-esteem and empowerment are important issues in treating women addicts.

CHASNOFF: They are major factors in the whole recovery process for women. Many treatment programs are based on a classic 12-Step model of Alcoholics Anonymous, which was in fact developed for men. Women don’t do as well in large groups, especially in coeducational groups. Also, in typical 12-step programs a first step is to give up one’s own power to a higher power.

But, we’re often dealing with women who never had any power in the first place to give up. So, rather than asking women to give up their power, we work from a position of empowerment — of gaining control of their lifestyles, controlling their environments, and especially controlling their relationships with men. Issues of sexuality and violence really come to the forefront when you’re working with women addicts as opposed to male patients.
A.T.F: It seems the issue of an addicted woman who is also pregnant presents a whole new set of problems.

CHASNOFF: When we start addressing issues of pregnancy and addiction we have a whole different milieu, both physiologically and emotionally for the woman. She’s at a completely different point in her life then, and there are concerns about whether the pregnancy was planned, whether she wants the pregnancy, her capabilities for parenting, and what kind of support she has from the father, if any.
A.T.F: Does pregnancy change the treatment process?

CHASNOFF: The treatment process itself doesn’t change as much as it has to be broadened to encompass a lot of other issues besides just addiction. In our program, we work with the women from two different perspectives. One is the woman as an adult, the other is the woman as a mother. These aren’t mutually exclusive, but certainly they each carry their own needs to be addressed.
A.T.F: Has the perinatal treatment of addicted women been underemphasized in the past?
CHASNOFF: Certainly the number of treatment slots for women, nationally, is nowhere near what it needs to be. Then, specifically, we don’t even have 10% of the treatment slots for pregnant women that are actually needed.
A.T.F: Why is that?

CHASNOFF: In the past, women were not the highest priority in drug addiction treatment. When you add the issues of pregnancy and the potential medical complications, many treatment programs were reluctant from an insurance perspective, if nothing else, to undertake caring for a pregnant, drug addicted woman and her developing fetus.
A.T.F: What is the greatest challenge ahead regarding the issues of addicted women, pregnancy and, subsequently, their children?

CHASNOFF: Stabilizing the field. A lot of information is emerging; we have to take that research and translate it into practice, so that there are some standardized, proven approaches that professionals can use. Right now, clinics around the country are using different techniques and approaches. We are getting to the point where there’s a recognition that a wide variety of services must be available to women, many more than for men.
A.T.F: Do you have any particular programs in mind that should be implemented? Or expanded?

CHASNOFF: I believe programs specifically for addicted women, especially if we can have programs for pregnant women, need to be put into the regular funding stream; rather than having to rely on special allocations from states or the federal government to keep them going. NIDA has in place right now what’s called the “Perinatal Twenty.” These are 20 demonstration research programs across the country that are cutting new ground and leading the way in developing these new methodologies. They were all funded for five years and all coming to an end just when we’re getting a lot of information out of them. Those need to be continued.

[For more information about NAPARE programs and publications write to them at: 11 E. Hubbard St.; Ste. 200; Chicago, IL 60611. Or, call: 312/329-2512.]
Patient’s Perspective

"Methadonian" Comes Out of The Shadows; "Methadone is ME," she says.

"I am a methadone maintenance patient [of the past 4 years]. I am white, female, and upper-middle class. I am considered a successful patient, both by the clinic’s and society’s standards. More important, however, I consider myself to be a successful, recovering addict. Four years ago, after suffering from 7 years of narcotic addiction [to oxycodone; generic name for a synthetic narcotic analgesic] following back surgery, my marriage of 18 years was on the rocks, my children wanted little or nothing to do with me, I had lost my job, stolen money from family accounts, had been in several serious car accidents and was close to having my body physically shut-down after years of opiate abuse. At that juncture, I had been in and out of 5 detoxes, 4 rehabs and numerous counselling and aftercare therapies. Nothing worked. At NO TIME did ANY physician ever suggest methadone maintenance treatment. And, when in desperation I queried the doctor, I was told, 'Methadone is for junkies; not for someone like you!' Even the physicians who treated me in detox 4 times failed to see me as the junkie that I truly was. That’s how uneducated and prejudiced he was in his thinking, especially regarding methadone maintenance. Only when successful methadone maintenance patients come forward and identify themselves as such will drug treatment professionals, as well as the public, come to know the tremendous benefits this treatment alternative can offer. ... Methadone is ME. ... Methadone maintenance has allowed me to reclaim my life, my marriage, my children. It is important to note, that methadone ALONE is not responsible for my recovery. I continue to attend counseling at the clinic on a weekly basis and am fully aware that, without the growth that therapy has afforded me, the methadone could not have existed in a vacuum."

Methadone maintenance has allowed me to reclaim my life, my marriage, my children.

Respond to A.T. Forum MMTP Clinic Survey

What’s Your Dose — Methadone

High dose. Low dose. Adequate dose. Confusion and controversy abound and you may be wondering where your own clinic stands in the nationwide portrait of methadone dosing practices. Some of our preliminary findings indicate a range of “average methadone doses” between 22 mg/day to 90 mg/day. Quite a broad spectrum! Of course, average numbers in isolation can be misleading. Much more data is needed to truly understand the practices and rationales of clinics around the country. So, help us help you better understand where your own clinic’s approach fits into the overall picture. Here’s what you can do:

- Complete the Feedback Card in this issue, today, and send it in to us. Fill-in all the dosing numbers or at least those readily available to you. We will need to know your geographic location for regional analysis purposes. However, your clinic’s name (if provided) WILL BE KEPT STRICTLY CONFIDENTIAL.
- Send us a brief note, with your philosophy behind the numbers. This sort of qualitative information will help us explain the reasons driving the statistics, thus leading to a greater understanding of dosage practices. We will only publish your name and affiliation with your prior permission (include a phone number where you can be easily reached).

Your Response Is Vital

Results will be published in the next issue of A.T. Forum. If we get a mere handful of responses to this survey, any analyses will be meaningless. So, if you believe this informational service can be of any benefit to you and others, RESPOND TODAY!
services, expanded preventive treatments.

**NOTE:** In his February, 1993 staff slashing, Clinton’s biggest cut was to the Office of National Drug Control Policy (the “drug czar”), down to 25 from 146.

**Plan for Change Outlined by Legal Center, Coalition**

Declaring that “the election of Bill Clinton presents a real opportunity to implement an effective national drug and alcohol policy,” the Legal Action Center and the National Coalition of State Alcohol and Drug Treatment and Prevention Associations have released a four-point Blueprint for a New and Effective National Drug and Alcohol Strategy, according to Paul N. Samuels, Esq., newly appointed President and Director of the Legal Action Center.

The plan calls for:

- Allocating at least 50% of the federal drug budget to prevention, treatment and research. This would increase funds for such purposes from $3.5 billion to $6 billion.
- Providing treatment and prevention services to all individuals involved in the criminal justice system who have drug or alcohol problems.
- Including coverage for comprehensive drug and alcohol treatment services in national health care reform.
- Addressing the economic and social factors that contribute to drug and alcohol problems. “Perhaps the best news in these difficult economic times is that additional federal funds will not be needed to implement this new approach,” said Ellen Weber, Legislative Counsel for the Legal Action Center. Instead, the plan calls for redirecting funds from current interdiction efforts that are not working and earmarking a portion of asset forfeiture funds for treatment and prevention activities, as 17 states have already done. The Legal Action Center is a non-profit law and policy office focusing on drug, alcohol and AIDS issues. The National Coalition is composed of 19 treatment and prevention provider associations from 18 states whose members primarily serve individuals who seek services in publicly-funded programs.

[For more information or a copy of the “Blueprint,” contact Paul Samuels at 212/243-1313. Or, write: Legal Action Center; 153 Waverly Place; New York, NY 10014.]

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**Looking At Legislation**

**Interim Methadone Passes Final Ruling; Where’s the Funding?**

On January 6, 1993, the FDA in conjunction with SAMHSA (State Alcohol and Mental Health Services Administration) issued Final Rule 21CFR291 revising the conditions for the use of interim methadone maintenance treatment. A primary objective is to stem the risk of HIV transmission among intravenous drug abusers who cannot immediately be placed in traditional methadone programs.

Methadone Maintenance now has two components: Comprehensive — providing methadone along with a range of appropriate medical and rehabilitative services (the current rule); Interim — treatment providing methadone along with limited services while a patient awaits transfer to a comprehensive regimen. Only public or private not-for-profit clinics can provide interim maintenance, and only if a patient can’t get into a comprehensive program in the geographic area within 14 days after seeking treatment.

A clinic must receive FDA and state approval before beginning interim maintenance. States must guarantee patients will be transferred to a comprehensive program no later than 120 days after enrollment in interim treatment. And states must not reduce capacity or funding of comprehensive programs to pay for the interim approach. Clinics must provide HIV counseling as part of interim treatment. While HIV testing is not mandatory, patients must have such testing available. Upon admission, patients should receive TB testing as part of a medical evaluation. Pregnant women are to receive priority.

Clinics must keep records on all interim patients. The state must be notified each time a patient enters interim treatment. No state is required to implement interim programs and, if they do, a critical element of the Final Rule is consultation between the state’s Chief Public Health Officer and the Alcohol & Drug Abuse Agency.

According to Mark Parrino, President, American Methadone Treatment Association, the Association has opposed the implementation of interim maintenance treatment all along because, “it would detract from and undermine the integrity of the treatment system.” He believes the interim concept is wrong because research has shown that when a person first enters an MMTP it is when she/he most needs counseling and comprehensive care.

Parrino asks, “If there’s no additional federal appropriations [for interim care] and the states don’t have the money [which they don’t] where’s it going to come from?” He claims, “No State Alcohol & Drug Abuse Director wants to implement this.” CSAT is planning to sponsor a meeting of states at the end of April in Arkansas to discuss the issues.

For further information contact Mark Parinno at 212/475-5572 or Thomas C. Kuchenberg, Center for Drug Evaluation & Research (HFD-362); FDA; 7500 Standish Pl.; Rockville, MD 20855 (301/295-8046).
Diseases On The Rise Among Methadone Patients

There is an increasing trend towards HIV and tuberculosis infection among drug users, according to Dr. Peter Selwyn, Associate Director of the AIDS Program at Yale New Haven Hospital. Drug treatment professionals need to learn how to identify the problem, how to prevent it, and how to respond. Selwyn described the increasing problem during a session entitled “Primary Care for HIV infection and TB” that was part of the National Methadone Conference in Orlando, Florida, November 10, 1992.

AIDS presents a different clinical picture in drug users than in other patient populations. Drug users are more likely to develop bacterial infections, such as bacterial pneumonia, endocarditis (inflammation of the lining of the heart), sepsis (the presence of infectious organisms and their toxins in the blood), and TB.

Dr. Selwyn has been following patients in a methadone treatment program since 1985. The results, recently published in The New England Journal of Medicine (1992; 327:1697-1703), show that large numbers of methadone patients are HIV positive and have low levels of immune system cells called CD4 cells. They should be receiving antiretroviral therapy (such as AZT) as well as other interventions that can increase their chances of survival. Dr. Selwyn noted that when patients in a methadone treatment program are offered antiretroviral therapy or prophylaxis for pneumonia in a supervised setting they exhibit high rates of compliance to treatment.

Antiretroviral drugs have not been shown to have any effect on methadone metabolism, though patients will sometimes assume they do, because of nausea, headache or insomnia that these drugs sometimes cause. Such treatment can be very beneficial: Dr. Selwyn found that methadone patients who took AZT had a lower rate of progressing from asymptomatic HIV infection to AIDS. He said that his study was the first demonstration that it is possible to favorably affect the natural history of HIV disease in drug injectors.

Another speaker was Dr. Lee Reichman, Professor of Preventive Medicine and Community Health at New Jersey Medical School in Newark, NJ, who discussed TB control within the context of methadone treatment programs. People at high risk of developing TB include those with HIV infection, people with other medical risk factors, foreign born people, medically underserved low income populations, alcoholics, injection drug users, and residents of long term care facilities. Of great concern to people who work in methadone maintenance treatment programs are outbreaks of multidrug resistant tuberculosis, which occur frequently among HIV infected patients.

What can a methadone maintenance

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Research Notes

NDA Due For LAAM In March, 1993

Labeling validation trials are currently underway for LAAM (a longer-acting methadone derivative) and, upon their completion, NIDA expects to submit the NDA for approval in March. Final approval could come as early as April at a meeting of the FDA's Drug Abuse Advisory Committee.

As reported in Health News Daily (December 11, 1992), preliminary data suggest LAAM has a "relatively benign safety profile," with dropout rates "about the same as those for methadone."

Naltrexone Studied As Alcoholism Deterrent

The Medical University of South Carolina, Yale, the University of Pennsylvania and Johns Hopkins have received NIAAA grants to study the effectiveness of Naltrexone in weaning people from alcohol. Two preliminary studies have already shown that the drug, along with intensive behavioral therapy, can help prevent relapses among recovering alcoholics. These new studies are expected to take four-years.