What would you change at your MMTP clinic?

Patient Survey

Common Concerns Expressed Around the Country

What is the single most important change you would make at the MMTP clinic you attend? That's the question we asked of MMT patients in the last edition of A.T.F. Forum [Vol. III, #1].

At the time of this writing, over 60 responses have been received from patients around the country. Here is a sampling of their comments:

"Responsible patients should be allowed once a week or even less frequent pick-up schedules." — New York.

"If you can't pay the weekly fee due to loss of job or personal crisis, the clinic will detox you down to zero, even if you are again able to pay the fee before being totally detoxed." — Florida.

"I have to travel 250 miles each week to get my methadone. I think a person clean for at least 5 years should be able to get medical maintenance from a private M.D. once a month so long as he stays clean." — Alabama.

"We need more than one clinic for the population in this area." — Ohio.

"I cannot think of anything I would change that would be workable across the board for all patients. This is also a well-run program." — Florida.

"We [husband & wife] make too much money for Medicare to cover our treatment, but the billing is too high. There needs to be a middle ground; we'd hate to have to leave treatment because we straightened up.

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MMTP Update

Locked Out, Patients Organize Own Clinic

It happened suddenly, overnight. The door was locked; the methadone clinic permanently shut down. What would the patients do?

For Tracy Gilmore and a strong group of other patients the answer was to begin organizing their own clinic — a classic example of, "take the sour lemons and make lemonade."

This happened in Des Moines, Iowa, in May, 1993. There had been private, publicly-funded, and community-based methadone clinics in central Iowa since the early 1970s. But one after another had closed over the years due to internal problems or lack of funding. The last clinic, only one of three in the state, had been in existence for 14 years when it was closed without warning due to alleged irregularities.

The state Department of Public Health acted quickly and arranged for methadone distribution at a local county hospital. For the patients, however, this wasn't the ultimate solution; they wanted something better in terms of enlightened dosing practices, patients' rights and other issues more consistent with progressive methadone maintenance treatment.

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Pay Now, or Pay Later...

This edition of A.T.F. addresses the question of financing MMT — who will pay? It impacts attracting patients to treatment, the quality of treatment and the retention of patients in treatment which can be so important for long-term progress.

Concluding from the comments of Drs. Robert Kahn and Thomas Payte appearing in this edition of A.T.F., one desired approach might be: Aggressively fund treatment slots for opioid addicts to get them into methadone maintenance; in the early stages, treat patients competently and comprehensively to get them back on track medically, socially and financially; as a result, they could then be in a position to pay for all or most of their treatment to free up entry funds for those still in need.

Once opioid addicts are well-established on methadone and have their lives back in order, their treatment could also be more affordable for them as individuals. For this, lower-cost medical maintenance or after-care programs appear to be viable approaches whose time has come for widespread acceptance and implementation.

A Survey Question for All...

In the past few editions of A.T.F., we’ve solicited reader responses to brief survey questions. For this edition, our challenge and invitation to readers is for your comments and opinions about a more general question:

**Methadone Maintenance Treatment: Who Should Pay? Why/How?**

MAIL or FAX your reactions to us - today - so we can include them in our next issue.

A.T. Forum
1515 Woodfield Rd., Suite 740
Schaumburg, IL 60173
FAX: 708/605-0137

NOTE: You can still use the postage-free feedback card to request unabridged copies of interviews in this issue or to be put on the mailing list.

Stewart B. Lewitt, Ph.D., Editor

Patient Survey continued from Page 1

our lives and got jobs.” — New York

“We are on a sliding pay scale and it’s unfair for people on federal assistance to pay nothing and stand in line with those of us who pay high fees for the same treatment and counseling.” — Maryland

“The most important change needed is to have dose levels and take home policies determined on an individual basis by M.D.s and not by the state.” — California

“When patients get a bad urine they should get an increase in methadone dosage.” — New Jersey

“Please add my counselor to your mailing list. He’s not aware that the proper dose for each patient is different and why.” — Maryland

“Clinics should not withhold doses to penalize patients for not living up to clinic rules. Isn’t that illegal?” — Wisconsin

“Quite hard to see the program physician for my problems. Otherwise, this is a good clinic and we’re fortunate to have it.” — Kentucky

“Counsellors don’t have enough time due to state paperwork.” — Illinois

“When a patient comes in for help something needs to be done immediately; not two weeks later.” — Minnesota

“Make the State Methadone Treatment Guidelines [from CSAT] law and treatment procedure in all clinics nationwide.” — Colorado

“We need more clinic locations. It takes me two hours each day to travel. However, best decision I’ve ever made was to seek this type of treatment.” — Georgia

Easy access to treatment, adequate dosages, more liberal take home privileges, curtailling punitive practices at clinics and how to pay for treatment were the most common themes. These concerns are all addressed to some extent in the other articles and interviews in this edition of A.T.F.
Gilmore joined with other patients to form a non-profit coalition called the "Heartland Recovery, Outreach and Information Network." This patient advocacy group lobbied state and FDA authorities to let them organize their own clinic. The authorities said if there was an alternative, community-based organization, they would consider giving them the contracts to provide outpatient services and methadone. Of course, they would need certified professionals as part of their program: medical director, pharmacist, addiction counselor, etc.

Spearheaded by William Shepherd, current Executive Director and methadone counselor with 30 years experience, Gilmore and other volunteers worked hard to develop the necessary paperwork to start their clinic; called the Mid City Addiction Team (MCAT). They wrote policies, procedures, methadone protocols and even a patient handbook while seeking to be licensed by the state, FDA and DEA.

The FDA and state authorities were helpful in providing information. The group also got sample protocols and procedures from other clinics around the country. A major goal was to avoid the shortcomings of earlier clinics in their area and, especially, eliminate any punitive approaches to patient dosing practices experienced in the past.

This was an innovative situation; there were even three patients on the 15 person MCAT Board of Directors. Gilmore says, "We wanted this to be a coalition, not totally overwhelmed or run by patients. We needed professional experts to help us and we wanted board members who were willing to work."

Board members include a lawyer, several community social workers, a certified counselor, a teacher and a private businessman. Of course, they also have the required medical professionals on staff at the clinic.

Today, MCAT is going strong and Gilmore — who has education and experience in business administration, healthcare and insurance — is the Administrative Director of the clinic and Executive Director of the "Heartland" patient advocacy group. Over the past year MCAT has more than doubled in size to 68 methadone patients. They offer outpatient services along with group and individual therapy. There is some state funding and supplemental patient fees are based on a sliding scale based on ability to pay. But, Gilmore stresses, they do not reject or discharge anyone, or withhold dosage, for non-payment.

The retention rate at the clinic has been excellent, according to Gilmore. Over the past year, only five patients have left because of voluntary detox or having been incarcerated. Only one has been dismissed for lack of progress on the program [chronic recidivism and drug overdose incidents], and that was after months of work by staff and fellow patients trying to help the patient and his family.

With regard to take home methadone, Gilmore comments: "At our old clinic, you had no idea of what the 'regs' were or what might be permissible or that we had certain rights as patients. When we started our own clinic, we studied all the regulations from front to back. We made it a step program; everybody from the outset gets some take home because we're closed on Sundays. Of course, we follow federal regulations regarding progressive take home privileges; so by the third year in treatment a once weekly pick-up schedule is permissible."

From the very beginning a unique aspect of MCAT has been the participation of patients. Besides three on the Board of Directors, there are patients employed at the clinic in support positions. Gilmore and her assistant (a methadone maintenance patient for 19 years) are in the process of being certified as counselors. Other patients volunteer their time to mow the lawn, clear the snow, and help maintain the facility — whatever needs to be done. "That's our philosophy," she adds. "We try to involve everyone, even if it's just their presence at a Heartland group meeting once a week. They're coming to something that's not mandatory and that definitely aids in recovery."

Might this sort of program be transferred to other parts of the country? Gilmore believes there is a lot of potential for other patient groups to do what MCAT has accomplished. She invites ATF readers who may be interested in learning more about the MCAT program and her experiences to contact her at 515/280-3860.
For a perspective on the future role of private, fee-for-service methadone maintenance treatment (MMT) programs, A.T. Forum interviewed Robert B. Kahn, Ph.D. With academic training in clinical psychology, he is the Chief Executive of clinics nationwide which he describes as "medical clinical delivery systems specializing in the treatment of addiction." His clinics treat about 8,000 methadone patients daily. In most cases, these "proprietary programs" [as he calls them] are 100% dependent on patient paid fees.

A.T. FORUM: Do you think fee-for-service approaches to MMT will become more important in the future?

KAHN: The private sector can be relied upon to care for a significant portion of the treatment population, teaching patients how to budget their limited funds. As public monies become increasingly less available, we need to become more creative regarding how we fund our programs. We need to minimize MMT's dependency upon public funds, arguably, promoting fiscal stability and less controversy. Unfortunately, we often provide indefinite subsidies, offering minimal or no incentive to patients to become self-sufficient.

A.T.F.: Are most opioid addicts really in a position to pay for MMT?

KAHN: It has been my experience that most patients are able to pay something. Monies should be made available to assist truly needy patients. The problem is how to develop an objective criteria that assesses these claims fairly. It is difficult to determine the exact percentages of those able as contrasted to "willing" to pay. Arguably, few individuals and some programs are not motivated to answer this question, given that alternative funding is available. My fear has always been that dependency upon public funds leads to a countertherapeutic treatment environment and system instability.

A.T.F.: Can subsidies and fee-for-service approaches work together?

KAHN: A good example of a successful cooperative effort is Orange County, California. In 1981 I wrote the Board of Supervisors proposing that they replace their 100% publicly subsidized program with both fee for service and a smaller publicly funded "specialty" clinic. At the time, approximately 300 patients were being treated at several locations, at a cost of 1 million dollars. Today, proprietary (fee for service) programs are treating the vast majority of the over 1,000 patients being served while the publicly funded clinic limits its services to specific patients, i.e. pregnant and disabled individuals. The savings realized from this venture have been used for expanded drug abuse treatment throughout the community.

A.T.F.: What about retention rates? In our last edition of A.T. Forum [Vol. III, #1] we reported on a clinic in San Antonio, Texas, where one of the factors relating to increased drop-out rates was a requirement to pay more for treatment.

KAHN: Fees can influence retention. The problem may have to do with the patient's ability to pay for treatment or, as often, their willingness to pay. To simply say that increased fees result in lower retention rates may not be entirely accurate. There is no question, however, that a 100% subsidized patient will remain in treatment indefinitely, all things being equal. However, in the big picture, do we do our community and patients a service when we provide incentives for patients to earn and contribute more toward their own treatment?

A.T.F.: At your clinic do you have any particular methadone dosing philosophy?

KAHN: In the 1970s, I realized that patients could help make their own determination about dosage. If you insist on controlling patients, your counselling and clinic atmosphere is characterized by argument and debate, largely due to a preoccupation over dosing and urinalysis procedures — especially when urinalysis is used punitively as opposed to clinically. Simply put: if you want the content of your therapeutic engagement with patients to be more personal and constructive, then you do not engage in a battle with your patients over what they ingest or what they excrete. The fact is, for patients to stay in treatment and be motivated it is extremely important that they feel they are being attended to properly. I use the clinic as a vehicle to allow people to progress in whatever way they wish, as long as it is safely. My one rule for patients has been, "Do not commit an overt act of violence." The safety of patients and staff cannot be compromised. However, notwithstanding this cardinal rule, patients, accompanied by maximum clinical support, are given a great deal of latitude to experiment with their lives.

A.T.F.: Does that "experimenting" include using opiates while in methadone treatment?

KAHN: As a responsible clinician I will not abandon my patient because he/she does not conform to my expectations. The continued use of unauthorized drugs challenges the clinician. The treatment program may also face potential sanctions by state or federal authorities. If we do not work with patients who continue to abuse other substances, they may be abandoned entirely. My fear is our impatience with these patients results less from our clinical than political concerns. Obviously, responsible clinicians have an obligation to employ whatever clinical interventions are available to them to minimize the problem.
Meeting Notes

National Methadone Conference 1994

“Changing Lives - Healthy Communities!” was the theme for the National Methadone Conference held in Washington, DC, April 20-23, 1994. The event featuring over three dozen informational sessions and educational workshops was sponsored by the American Methadone Treatment Association, Inc. Over 1,300 persons attended from more than 40 states and 25 countries.

In a “Report to the Field,” Alan Leschner, Ph.D., new Director of the National Institute on Drug Abuse (NIDA) focused on viewing drug addiction as a “brain disease.” As such it must be covered as a public health problem under health care reform and this impacts the way in which drug abuse service delivery is approached.

Dr. Leschner voiced his opinion that, over the past 3 decades, “methadone maintenance treatment has saved countless lives and has tremendously improved the quality of life for thousands. Today, methadone is recognized not only as an effective treatment for opiate dependence but also as a valuable tool for curtailing the spread of HIV.” As of September, 1993, IV drug use accounted for nearly one-third of adult/adolescent AIDS cases; 56% of reported AIDS cases in children were among those born to mothers who were injecting drugs or who had sexual contact with an IDU.

“We know from extensive research that medication alone is not sufficient for optimum treatment outcome,” noted Dr. Leschner. “Medication as co-therapy with good clinical programs is another NIDA priority.” The Institute intends to continue its commitment to changing the way in which people perceive drug addiction and in encouraging efforts to improve the image of methadone maintenance treatment. NIDA also plans to conduct and fund “the foremost research in the drug abuse field; and to [ensure] that this research reaches practitioners and others on the front lines in the most effective and useful way possible.”

Regarding research on other medications, Dr. Leschner observed that LAAM has currently been approved for dispensing in 12 states. “LAAM is not intended to replace methadone,” he said, “rather, it’s intended use is to provide the treatment community with more options and improved treatment matching for patients. It is hoped this new medication will help us progress from serving 100,000 individuals in need of treatment for opiate dependence to 200,000.

Ms. Lisa Schekel, Acting Director of the Center for Substance Abuse Treatment, also commented on the great improvements in methadone maintenance treatment and discussed CSAT’s plans for continuing to strengthen the integrity of the country’s methadone treatment system.

Dr. Lee Brown, Director of the Office of National Drug Control Policy, and Senator Carol Moseley-Braun of Illinois discussed the importance of including substance abuse treatment in national health care reform. Dr. Brown commented on the critical importance of treatment as a part of the Administration’s strategy in confronting drug abuse in America. Senator Moseley-Braun underscored the quickly changing face of health care reform in Congress.

Peter Edelman, Drug Policy Advisor to the Secretary of HHS, presented the most critical drug policy initiatives within his department and acknowledged the importance of methadone maintenance treatment in combating addiction and HIV infection. Kristine Gebbie, National AIDS Policy Coordinator, cited the need for continued collaboration between her office and substance abuse treatment services as a means of providing cross-fertilization of expertise.

Mark Parino, President of the American Methadone Treatment Association, Inc., offered several recommendations regarding policy. High quality, comprehensive methadone treatment services should be made available for all individuals who will benefit. The length of time that patients can receive methadone should be determined by treatment providers on a case-by-case basis.

Under health care reform, MMTPs should be designated as “essential providers,” allowing them to compete with HMOs. Adequate coverage must also be provided for pregnant addicted women, addicted women with children, and addicted homeless people.

Here are some Fast Facts From CSAT (Center for Substance Abuse Treatment) ...

- MMT is currently provided at more than 725 FDA approved outpatient programs treating about 115,000 patients in 41 states.
- MMT decreases opiate abuse in over 80% of patients.
- MMT reduces criminal activities and resultant costs to society in 80% of patients who remain in treatment for one year.
- Patients who remain stable in MMT are typically employed.
- MMT improves the health of heroin and other opioid dependent people by early identification of medical problems like tuberculosis, and continued health maintenance.
- Overall, according to NIDA, every dollar spent on drug treatment saves $4 to $7 in reduced costs to the public and contributes $3 in increased productivity.
Clinical Concepts

The Role of Retention in MMTP

At the recent National Methadone Conference, Ward S. Condelli, Ph.D., and J. Thomas Payte, M.D., presented a session on "Strategies for Improving Retention" in Methadone Maintenance Treatment Programs. A.T. Forum first interviewed Dr. Payte, Medical Director of Drug Dependence Associates, in San Antonio, Texas, for our second issue [Vol. 1, #2]. We contacted him again for his firsthand views on retention issues.

A.T. FORUM: In your presentation you discussed three areas — ease of clinic access, quality of social services and individualized treatment — as being more important than patient characteristics such as age prior drug use, etc.

DR. PAYTE: Program characteristics are the things that we certainly have more control over. So I think that’s where we need to focus our attention. Accessibility of the clinic is very important in terms of operating hours, geographical distances, parking. We’re proposing a new building for our program and one of the things we want to put in is a special area for children while the parents are with their physician or counselor.

A.T.F.: Do you think community-based clinics would be better than any kind of centralization?

PAYTE: I don’t mind centralization if there are satellites. I would prefer to see as a program gets bigger and bigger that they develop remote medication dispensing units. Patients would still come into the main clinic for counselling, physician contacts and other services.

A.T.F.: Is the mere length of time spent in treatment an important factor?

PAYTE: In 1993, Ward Condelli and George Dunteman presented a study demonstrating the percentage of patients using heroin after exposure to various lengths of time in treatment [see, “Exposure to Methadone Programs and Heroin Use,” Am. J.

Drug Alcohol Abuse, 19(1), pp. 65-78 (1993)]. They started their study a year prior to treatment when 100% of patients were using heroin. Then they compared several lengths of treatment: short-term exposure to methadone treatment, less than 3 months; long-term exposure, 3 or more months; and, continuous exposure, meaning patients never left the program, or left but were exposed to other programs for more than 40 weeks during a follow-up year. Those heroin users who had even short-term exposure decreased to 39%, which was similar to the 40% of patients with long-term exposure. The important finding was that only 17% of those patients in continuous exposure to methadone treatment used heroin during the previous year. [See chart.] The debate continues about the duration of therapy; I strongly feel that there should be no arbitrary time limits on treatment and it should be continued for as long as the patient wants and benefits from continued treatment.

A.T.F.: In terms of a quality of clinic or social services, we hear stories of methadone being used in punitive or other ways to manipulate patients’ behaviors. How do you feel about that?

PAYTE: A number of people have used methadone as a part of contingency contracting, both as a negative and positive reward. At a policy level, supported by both the American Society of Addiction Medicine and the American Methadone Treatment Association, we generally maintain the position that dosage is a clinical consideration and should never be used as a carrot or a stick in terms of any kind of contingency contracting. I think it is entirely appropriate to modify take home privileges when patients don't participate in treatment or progress toward rehabilitation; not because they're being punished, but because they're not demonstrating their responsibility to take care of the medication. But, I've also talked to a lot of patients who have been on different

Continued on Next Page
programs and it's discouraging to hear the extent of complaints and horror stories about their experiences.

A.T.F.: To what extent might patients be expected to pay for the better quality of social services and individualized treatment that improve retention?

PAYTE: In most cases, patients come into treatment unemployable, they are physically sick and, of course, they're addicted. Then as they stabilize, quit using illicit drugs, gain physical health, and become employable they certainly should participate more in the cost of their treatment. However, it also is a fact that, the way programs are structured and the way regulations are designed, program costs remain fairly constant regardless of the patient's time in treatment. I think the way to go is a blending of the public and the private sector that will make treatment on demand available at the point of entry. But then a part of the ongoing treatment system would be to make these patients more and more responsible for their care, so as they progress through the system a smaller portion of the burden falls on the taxpayers. What I'm hoping to see in the future is a move toward more after-care and medical maintenance at considerably reduced costs.

A.T.F.: Is there a flip-side of the retention issue; that is, patients just not coming into treatment in the first place?

PAYTE: I think it's ridiculous to have four or five addicts who are NOT in treatment for every one that's in treatment. We do have a problem with patients dropping out of treatment. But, if there are a half million to one million active chronic heroin addicts out there, why are most of them not even coming into treatment? What we have is a "dropping-in problem."

A.T.F.: What's keeping these addicts away?

PAYTE: For one thing, they know treatment is not easily available. Most of the publicly funded clinics have waiting lists. Second, treatment may not be acceptable to them. We need to look at patient acceptance as we design our programs; not necessarily what's best from the clinic's standpoint, but what's best to bring more people into treatment and retain them there. So, in sum, I think we need a user friendly system that is affordable from the outset. And we need the commitment of adequate resources to really provide an intense, high level of total care for the first year or two. Then, after three or four years, these retained patients who are socially rehabilitated, trained and employed could be paying their own way and the cost of the treatment will drop dramatically. I think it could cost only $50 to $75 a month to have a patient on medical maintenance, including the professional's fees and the medication.

For a complete, unabridged transcript of this interview please check the appropriate box on the feedback card in this issue and mail it in.

RESEARCH NOTES

Long Lasting Benefits of MMT

This study examined continued illicit substance abuse by 229 patients in MMT as a function of time in treatment: from three months to over 10 years. Urinalysis results collected over a 3-month test period indicated that cocaine use, while a problem among MMT patients, is not related to length of time in treatment. Also, cocaine use did not lead to increased opiate and other illicit drug use.

Opiate abuse did decrease significantly with time in MMT treatment. While 35% of patients in MMT for less than 12 months were opiate-free during the 3-month testing period, a full 71% of patients enrolled for over 4 years and 85% of patients in treatment for over 10 years were opiate-free.

The authors concluded that, "The longer an opiate addicted individual remains in treatment, the greater the likelihood is that he/she will cease to abuse opiates. Undeniably this is of extreme importance given concern regarding the spread of HIV in intravenous drug abusers. It is important to emphasize that the impact of methadone on continued opiate use is progressive...and positive life change takes time and continues over time."


Methadone Okay for Long-term Use

In a recently reported study, the researchers commented on the long-term — up to 18 years — benefits achieved by MMT patients. Over 100 male patients, who were admitted to methadone treatment in the mid-to-late 1960s and were still enrolled in 1980 in continuous treatment for at least 10 years, were included in the study.

The authors concluded that, "...long-term methadone maintenance treatment is safe and is not associated with unexpected adverse effects. Abuse of cocaine and alcohol become less frequent during long-term [MMT] but remain significant problems for many individual patients. We conclude that methadone maintenance results in an overall improvement in health in former heroin addicts and should be continued as long as the patient, physician and other treatment staff believe that it is of benefit."

MMT continued from Page 4

A.T.F.: In terms of the future for your proprietary, fee-for-service program, do you feel optimistic about the way it will fare under the Clinton administration's health care initiatives?

KAHN: I am very concerned about the impact of a national health care program on MMT's. It is possible that a fiscally motivated system may not tolerate the protracted treatment episodes necessary to treat a 'chronic and relapsing' disorder. To the lay public the disease seems to matter less than its genesis. Our patients are not empathized with and are often viewed as responsible for their affliction. Given limited funds, narcotic dependent persons may be competing with cardiology and gerontology patients for care.

A.T.F.: What's the greatest criticism that you think might be leveled against your program's approach by detractors?

KAHN: That I may be tempted to subordinate health care to profits. I submit that publicly funded programs seldom request less money each year. The fact of the matter is that the treatment community is characterized by well intentioned and honest professionals, first and foremost concerned with the welfare of their patients. In my over 25 years of experience, I have met very few clinicians who would knowingly compromise a patient's care to make more money or justify increased funding.

For a complete, unabridged transcript of this interview, check the appropriate box on the feedback card in this issue and mail it in.

Forum Feedback Letters

"Methadone Anonymous"; Right! — A Rebuttal

The following is in response to a feedback letter by Stan Novick, president of NAMA, which appeared in the last edition of A.T. Forum. The caption was "Methadone Anonymous; Wrong!"

Mr. Novick states that "all anonymous groups are against the word that precedes that term, e.g., Alcoholics Anonymous is against alcohol." However, if Mr. Novick would read the chapters by Bill Wilson in Alcoholics Anonymous Comes of Age he would be enlightened to the fact that Mr. Wilson was not "anti-alcohol," he was interested in treating alcoholism.

Methadone Anonymous is not "anti-methadone," it is pro-methadone and anti-discrimination.

As founder of Methadone Anonymous, I chose the name because I wanted to emphasize that the use of methadone is a private medical decision on the part of the user. It should NOT be an issue of one's recovery. Consequently the use of methadone is never discussed at a Methadone Anonymous meeting; only abstinence from heroin and continued recovery are appropriate topics at [our] meetings.

In closing, let me say that Methadone Anonymous is alive and doing very well. We have no time for bitterness or animosity with anyone. We support all 12-step groups even when we sometimes disagree with what they may say about methadone users....

Gary Sweeney
President, National Board of Directors
Methadone Anonymous, USA

[Editor's note: According to Sweeney, from their original four chapters in Baltimore, Methadone Anonymous has spread to chapters in 47 states. Those with questions about the program may contact him at 410/837-4292.]