

Forum

THE QUARTERLY NEWSLETTER FOR CLINICAL HEALTH CARE PROFESSIONALS ON ADDICTION TREATMENT

Vol. 11, #1 • WINTER 2002

Disaster has many ugly faces and can strike any time to put an MMT clinic out of business.

IN THIS ISSUE

DEALING WITH DISASTER	P. 1
LIVER DISEASE IN MMT: PART 2	P. 1
EVENTS TO NOTE	P. 2
EDITOR: CHANGE THE ORDER OF TODAY	P. 2
PRACTICE POINTERS	P. 5
HCV INFO ON THE WEB	P. 6
SURVEY - TALKING TO PATIENTS	P. 8

Current Concepts

Dealing with Disaster

Disaster has many ugly faces. Natural disasters, like hurricanes and earthquakes, reveal awesome destructive forces of the physical world. Manmade catastrophes, like the September 11, 2001 terrorist attacks and biological weapons scares in following weeks, remind us of our vulnerability to forces of evil and aggression.

Disaster can strike anytime. And, as the attack on the New York World Trade Center demonstrated, a crisis anywhere in the vicinity can disrupt methadone maintenance treatment (MMT) clinic operations.

When *AT Forum* addressed these issues about 5 years ago,[1,2] only 59% of clinics responding to a survey had disaster plans of some sort. These primarily dealt with natural disasters, such as weather emergencies, earthquakes, floods, or fires. Only a few had considered manmade crises, mostly bomb threats or riots.

Safety and continuity of patient care were, and still are, prime considerations. Notably missing were mental health considerations; that is, dealing with the psychological impact of events on patients and staff.

The horrors of last fall quickly tested the preparedness and response capabilities of MMT programs.

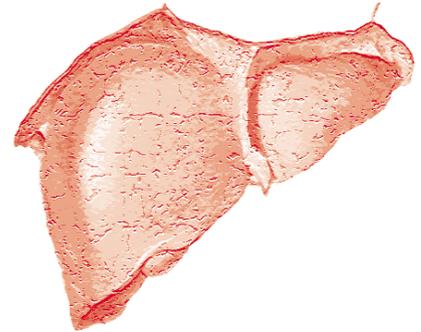
MMT Clinic Response in New York

Following the terrorist attacks in New York City, the addiction treatment community started the difficult task of helping patients and staff in need and assessing the physical, emotional, and economic damage. According to one report, operational and facility damages

Liver Disease in MMT: Treatment & Transplant

Part 2: Hepatitis C - A "Giant Silent Killer"

In merely a decade, researchers have gone from characterizing hepatitis C (HCV) as a "sleeping giant"[1] to an "awakening giant." [2] Meanwhile, many others have called it a "silent killer."



The first article of this series[3] noted that about 9 out of 10 of persons entering methadone maintenance treatment (MMT) programs are likely to be infected with HCV. Of those, roughly three-quarters will develop chronic liver disease.

Although there appear to be many barriers to HCV treatment for MMT patients, there also is cause for hopeful optimism.

Treatments Improving

HCV treatments continue to evolve and improve, and treatment outcomes are determined by measuring virus particles in the blood. The absence of virus at the end of HCV therapy, called an end-of-treatment response (ETR), is a preliminary sign of treatment effectiveness.

However, a more accurate indicator is the sustained virologic response (SVR). This is defined as the absence of virus 6 months after the completion of treat-

Continued on Page 3

Continued on Page 6

Events to Note

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

MARCH 2002

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

APRIL 2002

**Co-Occurring Psychiatric & Substance
Related Disorders Conference**
April 4-5, 2002
Yakima, Washington
Contact: DASA 1-877-301-4557 or
360-438-8200

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

MAY 2002

NAATP 2002 Annual Conference
May 19-21, 2002
Marriott Mountain Shadow Resort;
Scottsdale, Arizona
Contact: 717-581-1901;
Rhunsicker@naatp.org

Black Alcoholism & Addictions Institute
May 24-28, 2002
Atlanta, Georgia
Contact: 914-632-1611

JUNE 2002

Pain & Chemical Dependency
June 6-8, 2002
Sheraton Hotel/Towers; New York, NY
Contact: 404-233-6446;
www.painandchemicaldependency.org

**College on Problems of Drug Dependence
(CPDD)**
June 8-13, 2002
Hilton Quebec, Canada
Contact: 800-759-5800;
group@sailairtravel.com

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

JULY 2002

**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

Change - The Order of Today

Charles Dickens once wrote, "Change begets change. Nothing propagates so fast." Certainly, those words aptly describe the addiction treatment field today.

New Faces in Old Places

A virtual changing of the guard has been taking place in Washington, DC.

First, last fall, Charles Curie was confirmed as the new administrator of SAMHSA (Substance Abuse and Mental Health Services Administration). He previously served in posts in mental health and substance abuse services in Pennsylvania.

In December, John Walters was confirmed as Director of ONDCP (the White House Office of National Drug Control Policy). He had previously served at ONDCP from 1989-1992.

With the recent confirmation of Andrea Grubb Barthwell, MD as the Deputy Director for Demand Reduction at ONDCP, the methadone maintenance field will be well represented. She is superbly qualified for the post, with extensive experience as a methadone treatment provider.

Also last December, Alan Leshner, PhD departed as Director of NIDA (National Institute on Drug Abuse), a post he had held since 1994. Glen Hanson, DDS, PhD was appointed Acting Director of the institute by Ruth Kirschstein, MD, Acting Director of NIH (National Institutes of Health).

In January 2002, Raynard S. Kington, MD, PhD was named Acting Director of NIAAA (National Institute on Alcohol Abuse and Alcoholism). He had served in a number of posts at NIH during the past couple of years. His appointment followed the retirement of Enoch Gordis, MD, who had served as Director since 1986.

Most recently, ASAM (American Society of Addiction Medicine) announced that James Callahan is retiring this April after 12 years as Executive Vice President and CEO. A search is on for a replacement, so, if you know anyone who might be interested, have them contact ASAM.

Uncertain Outcomes Ahead

With all the leadership changes, and tentative, "Acting Director," appointments, things might seem a bit unsettled. Furthering that perception, there has

been talk recently of a "restructuring and delayering" process throughout the Department of Health and Human Services, but the outcome of this is uncertain.

One possibility is a merger of NIDA and NIAAA, as both are addiction-related research institutes at NIH. A provision added to a Senate bill called for a study to determine if combining the two institutes – forming a National Institute on Addiction – would strengthen research efforts and be more economically efficient.

Meanwhile, all of these past and potential changes have kept Mark Parrino busy as head of AATOD (American Association for the Treatment of Opioid Addiction, formerly called AMTA – another change). He has been meeting with the new leadership in Washington, DC to promote AATOD's latest five-year plan announced last fall.

Survey – Disaster Aftermath

Certainly, the events of last September may have brought about the greatest changes of all, challenging business-as-usual practices at MMT clinics everywhere. As a follow-up to our article in this edition on "Dealing with Disaster," we want to survey our readers' experiences.

Following the tragic events and bioterrorism scares of last fall, 2001...

1. Did your MMT clinic revise its disaster preparedness plans?

___yes; ___no; ___don't know

2. Was there an increased demand for treatment services?

___yes; ___no; ___don't know

3. Were there higher rates of drug relapse among MMT patients?

___yes; ___no; ___don't know

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>

A.T.F.

Current Concepts Continued from Page 1

were more than \$17 million.[3]

According to John Perez, Director for Methadone Planning & Policy at the New York State Office of Alcoholism and Substance Abuse Services (OASAS), New York is the largest center of MMT in the world, with 125 clinics statewide and a capacity of nearly 46,000 patients. He said clinics were immediately granted as much flexibility as possible and authorized to treat patients from other programs.

Henry M. Bartlett, Executive Director, Committee of Methadone Program Administrators of New York State, Inc. (COMPA), recalled that very few clinics in New York City were completely closed. The problem was that all civilians, including patients, were denied access to a large area surrounding the World Trade Center.

Perez said that past preparations for snow emergencies and threatened transit strikes served well as a model for response. When patients went to any of the licensed MMT clinics in the New York System they were able to receive their appropriate medication – professionally and efficiently.

Peter Coleman, President of COMPA, observed that some clinics had 50 to 100 extra patients. This was particularly the case in outlying areas because patients couldn't get into Manhattan.

"MMT clinics should be commended for their desire to take care of patients first and worry about reimbursement and other administrative matters second," Bartlett added.

Proactive Strategies Needed

During an interview last December, H. Westley Clark, MD, JD, MPH, Director of the Center for Substance Abuse Treatment (CSAT), indicated that, like everyone else, MMT clinics fall into thinking of dealing with disasters only if and when they happen. In today's environment, however, that strategy needs reassessment.

Potentially traumatic events must be addressed proactively, Clark asserts. MMT clinics need plans for addressing administrative concerns, such as networking with other programs, and so forth.

CSAT has addressed administrative disaster planning in the past, he said, but now there is a need to rethink that planning process to address added components and with varying strategies. For example, persons previously, but not currently, in treatment may need special support groups to help prevent relapse to opioids.

**When disaster strikes,
the casualties are
not the only victims,
and the effects are
stronger when the
trauma in question
is manmade.**

Patients currently in treatment may be more prone to relapse or exhibit antisocial behaviors, Clark continued. MMT programs need to recognize that traumatic events can cause such changes and address the issues proactively and with empathy, rather than treating it as merely bad behavior.

Addressing Psychological Fallout

When disaster strikes, the casualties are not the only victims, and the effects are stronger when the trauma in question is manmade versus due to an unavoidable force of nature. Persons who have suffered past trauma are even more vulnerable.[4]

Clark noted that there are several spheres of involvement. The inner circle includes casualties directly affected. A circle around that includes people who witnessed the event but were not victims. Outermost, would be people who heard about the event but did not witness or experience it firsthand.

After the New York and Washington, DC incidents, extensive media coverage expanded the "circle of witnesses" to the events, with a great many persons feeling as if they were actually experiencing the trauma. A RAND survey found that 44% of adults and 35% of children reported substantial symptoms of stress in the hours and days following the September 11th attacks.[5]

The challenge is that the fallout of psychological damage is much more subtle than a destroyed building or operational disruptions. Some experts have noted that exposure to trauma puts an individual at 4 to 5 times greater risk of substance abuse, and stress is the most major cause of drug relapse.[6]

Following the tragedies of September, the National Center on Addiction and Substance Abuse (CASA) at Columbia University surveyed substance abuse programs around the country. Preliminary national data indicated that treatment admissions had increased by up to 12%, particularly in cities and states closest to

the terrorist attacks, and in Florida, the site of the first anthrax reports.

Actually, there was a precedent for such psychological consequences of disaster following the Oklahoma City Bombing. After the community lost 168 people in the Federal Building catastrophe, nearly 76,000 people received treatment for post traumatic stress disorder (PTSD) and related problems in a variety of substance abuse and mental health settings. That's a 450 to 1 ratio![7]

The Dilemma of PTSD

As Clark observed, the horrors of September 11th were inescapable, even if only witnessed via news reports, and could have devastating consequences in persons with increased vulnerability due to PTSD or other past experiences. People with histories of PTSD, or even depression and anxiety associated with prior trauma, have increased vulnerability to new trauma, and such persons are over-represented in MMT programs, he said.

In MMT programs there is also a need to deal with people having co-occurring disorders, according to Clark. "For the individual patient, it is not simply a question of 'can I get my methadone dose?' It also is a matter of 'is my depression getting worse; is my anxiety or schizophrenia getting worse; do I need more medication?'"

Coleman noted that, rather than one or two patients coming in with problems, MMT clinic staff were confronted with 200 requiring assistance of some sort during weeks following the terrorist attacks. There also was an increase in relapses, including secondary substance abuse by patients in treatment and former patients looking to come back into treatment.

Staff needed urgent training on the debriefing process and dealing with patients' anxieties and feelings, Coleman said. Relapse prevention techniques became critical.

Clark asserted that treatment plans need to be quickly modified in the face of new trauma to account for a possible resurgence of PTSD and other mental health issues. Yet, during his discussions with MMT clinic administrators, he said, "One of the startling things we discovered was that some programs simply did not ask their patients, and staff, if or how they were effected by the traumatic events of last September."

Helping the Helpers

People working in the addiction treatment field often must continue taking care

Continued on Page 4

Current Concepts
Continued from Page 3

of others, putting their own needs second, even when they have been personally affected by a traumatic event. Additionally, they often find it difficult to ask for psychological support, since they are caretakers and often feel they should be strong for the people they serve.[8]

Self-medicating with alcohol or drugs is a major threat among helpers, even those who may never have abused substances in the past.[9] Helpers may not be their own best teachers, yet they are deserving of the same services that they deliver to others.

As CSAT's Clark observed, some MMT clinical staff may be in recovery themselves. From a clinical viewpoint, programs need to be ready and able to deal with their own professional staff who might have histories of trauma.

JCAHO Outlines Requirements

Might renewed needs for disaster planning affect the MMT clinic accreditation process?

Some new guidance has been provided by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which devoted the entire December 2001 issue of its publication, *Perspectives*, to emergency management.[10] JCAHO standards require behavioral health facilities, including accredited MMT clinics, to develop, implement, and execute plans that ensure effective response to emergencies affecting the entire "environment of care."

JCAHO defines an emergency as any natural or manmade event that disrupts the environment, hinders delivery of care and treatment, or increases the demand for services. Facilities must conduct a formal hazard vulnerability analysis (HVA).

An HVA identifies disasters most likely to strike a clinic and/or its community, and their probable impact if and when they happen. Possible threats may occur internally (within the clinic itself) or externally (in the community but affecting clinic operations in some way). **See chart.**

Part of an emergency management plan involves the need to cooperate with other healthcare organization within the geographic area to establish alternate care sites and to develop processes for information sharing. JCAHO specifically states that MMT clinics must provide:[10]

- links with community agencies to ensure emergency dosing capabilities;
- 24-hour telephone answering capability to respond to emergencies; and
- updated patient rosters and medica-

Possible Threats to Persons & Clinic Operations (modified after JCAHO [10])	
<p>Security</p> <ul style="list-style-type: none"> • bomb threat • civil disturbance • gang-related activity • hostage situation • location in high-crime area • terrorist attack (incl. explosive, nuclear, biological, chemical) • workplace violence <p>Catastrophe (Internal or External)</p> <ul style="list-style-type: none"> • airplane, train, bus/auto crash • chemical or hazmat spill/release • explosion • fire/smoke • flooding • gas leak • other building damage • other upheaval in community 	<p>Utility Failures</p> <ul style="list-style-type: none"> • telephone/communications • electrical • HVAC • natural gas • alarm/security system • water/sewage <p>Weather</p> <ul style="list-style-type: none"> • snowstorm • ice/severe cold • high winds/hail • tornado • hurricane • earthquake • severe rain/flood • severe heat/humidity • sinkholes

tion dosage logs that are accessible to staff.

Emergency management plans also must address staff needs, including incident stress debriefings. And, all staff (and patients) must be educated about their roles and responsibilities in the clinic's emergency management plan.

Possible Changes Ahead

Following the September disasters, the New York methadone provider community pulled together very cooperatively, heroically in a sense, to deliver services, according to Barlett. "The State also did a good job of followup," he said, "OASAS staffers stayed at their posts responding to MMT programs even after their offices were closed for security reasons.

Yet, Bartlett observed, although patients were medicated almost without interruption, a major concern was providing proper methadone dosing.

Fortunately, in New York there has been a policy of informing patients of their methadone doses, Perez noted, and patients did accurately represent their doses at host clinics. Bartlett and Coleman concurred that patients were honest about their methadone doses, but there were frustrating delays for some patients when questions arose.

COMPASS is exploring the creation of a regional patient-dosing database. This also might function as a patient registry, so patients do not enroll at multiple clinics. The database could contain other medical information, such as adjunctive medications or drug allergies. Merely assuring that patients receive proper methadone doses might only be doing half the job as far as meeting medical needs during an emergency.

CSAT Ready to Assist

"We believe that disaster planning is an integral part of clinic operations and we want to work with methadone provider groups to address this in a participatory fashion," Clark said. "We wouldn't want to impose obligations on clinics that they cannot meet, will hamper their operations, or increase their costs."

Clark indicated that there are efforts within CSAT to help pull together information on developing disaster response plans for MMT clinics. Clinic administrators and others in the field should contact Robert Lubran <RLubran@SAMHSA.gov> to provide their suggestions.

Clark noted that some documents to help clinics may be ready by this spring. Meanwhile, SAMHSA has fact sheets on PTSD at its web site (www.samhsa.gov).

Also see the "Disaster Aftermath" survey in this issue of *AT Forum* (page 2).

1. Disaster preparedness – are you ready? *AT Forum*. 1995;4(2).
2. Disaster planning revisited: more info available – a case example. *AT Forum*. 1996;5(2).
3. N.Y. agency, providers cope with aftermath of tragedy. *Alcoholism & Drug Abuse Weekly*. 2001;13(26):1-2.
4. Full impact remains uncertain. *Behavioral Healthcare Tomorrow*. 2001 (December);10(6):SR20.
5. States engage in post-Sept. 11 planning at SAMHSA summit. *Manisess BHT Newswire*, November 20, 2001.
6. NIDA (National Institute on Drug Abuse). Stress and substance abuse: a special report. Available online at: <http://www.drugabuse.gov/stressanddrugabuse.html>.
7. The COMPASS Bulletin. 2001 (October);1(6). Available online at: <http://www.compa-ny.org>.
8. The COMPASS Bulletin. 2001 (November);1(7). Available online at: <http://www.compa-ny.org>.
9. Enos G. How do we help the helpers. *Behavioral Healthcare Tomorrow*. 2001 (December);10(6):SR32.
10. JCAHO. Emergency management in the new millennium. *Joint Commission Perspectives*. 2001(December);21(12). Entire issue available online at: <http://www.jcrinc.com>.

Practice Pointers: How Families Affect MMT Success

By Andrew Byrne, MD*

Family members including relatives, significant others, and close friends can be vitally important to the success of patients in methadone maintenance treatment (MMT). These people can either help or hinder recovery.

It is frequently challenging enough convincing patients that they need MMT. So it is a double whammy when family members come into the clinical picture afterward, often not knowing the whole story, and asking the same questions as the patient. And we usually have a number of extreme perspectives to deal with.

Relinquishing Denial and Guilt

On the one hand there are pesky family members who just cannot believe that their loved one is actually a drug addict at all. They are usually quite vocal and assertive about their otherwise impeccable spouse, partner, child, friend, etc.

"They're too nice (or 'too smart,' 'too young,' etc.) to be an addict needing that terrible drug, methadone," family members protest. Or, "He/she doesn't REALLY need that much methadone, do they?"

This attitude stems from in-built human traits, not the least of which is a failure to accept the facts – meaning 'denial.' Sometimes the problem is a profound personal guilt in disguise.

For example, all parents naturally question whether the up-bringing they gave their addicted offspring was deficient in some way. This also extends to all other perceived defects: "I don't know why he/she turned out be gay" (or "a smoker," or "a gambler"). Family members can be very hard on themselves.

Sometimes, after strong family pressure, a patient valiantly comes down in methadone dose. The relatives then feel they were right all along. Indeed, they may harbor a conceited pride in bringing about this wonderful feat.

What they need to know is that, despite common belief, addicts do have quite a degree of control over their drug taking. Thus, patients can often get by with a lower dose for a period of time.

However, after continued goading from family, a further dose reduction may well lead to a drug relapse. I've seen it a hundred times! In this instance, those family members take no responsibility, but blame the patient and/or clinic staff for the relapse.

Adopting Time and Patience

On the other hand, there are the compassionate family members who have suffered for years with the patient's addiction. They know addiction does not just go away overnight. They fully trust that with perseverance on methadone progress is possible.

Still, these caring and kind people need to be reminded that the patient needs time, patience, and, foremost, individual responsibility in all this. Furthermore, a reasonable methadone dose for a reasonable period of time also is critical.

Adequate methadone dose is usually between 60 mg and 120 mg per day, but some patients will need much more for metabolic reasons. Also, some patients may need the drug for many years, perhaps indefinitely, while others manage to gradually withdraw over time.

Family members need to be reassured that only a regular, compulsive opioid user (usually heroin, but not always) would be assessed as appropriate for methadone. Furthermore, only an addicted person who was benefiting from MMT would continue to put up with the very real and continuing expense and hassles of most currently available programs. These include regular clinic attendance, doctor visits, and urine tests, to name a few.

Opening Doors to Family

I once worked with a world famous cancer specialist who came right out and said, "I do not treat the family, thank you very much!"

That is a hard concept. His attitude was that there were other professionals who could deal with families. He wanted to concentrate on the disease.

To my mind this is an outrage, since only a researcher in a laboratory can treat disease in such isolation. In our case, all clinic staff involved with substance-dependent patients must be prepared to deal daily with family members.

Although family involvement can be very important, honesty and openness are often new to the scene when treatment starts. I keep an open door policy, suggesting that patients bring in their spouse or partner, parents, or other family when they are ready to do so.

These persons are encouraged to talk about the situation, ask questions, and, importantly, reveal any misconceptions or prejudices they may have. At that meeting it is important to make it clear just how the

family member can become involved in the therapeutic process.

Many patients may balk at involving others. In early treatment, some do not even want family or associates knowing that they are on methadone. And they ARE entitled to some privacy in this, just as with any other medical matter.

However, those who think that their friends or relatives do not know that they were on drugs and now are in some form of treatment usually are mistaken. Drug use can indeed be hidden for many years, but by the time treatment is necessary obvious signs have become apparent in the patient's appearance, behavior, or finances that make it clear something is awry.

Overcoming Obstacles

Family members, as well as patients, need to understand that MMT can be a difficult road, littered with obstacles and stigma. Is addict a dirty word? Is heroin a dirty word? Is methadone a dirty word?

I spend half of my time trying to convince addicted patients that they are worthy folk and that their drug dependency is not a moral failing, nor was their choice of drug inherently evil. That can be difficult, since society teaches that alcohol is OK but heroin is deadly.

From a purely physiological point of view one can liken heroin to nicotine. We can point out the close similarities regarding addiction rates, abstinence and relapse rates, relative toxicities, antisocial/social uses or abuses (smokers are now outcasts in some areas!).

The principle of nicotine gum or patches for smokers is closely parallel to methadone in opioid addiction. Nicotine replacement therapies supply a much longer acting form of the drug in a safer manner, so the patient can focus on other things in life than taking a dangerous, short-acting drug.

With methadone, some patients suffer side effects, which also can be concerning to family members and patients. But, all too often, patients are reluctant to tell their doctors about these problems.

When describing common methadone side effects of constipation and excessive sweating, I once was challenged by an experienced American doctor. He said he had never heard of such things and that they must be terribly rare. I think his patients protected him from uncomfort-

Continued on Page 6

HCV Info on the Web...

The following Web sites offer important information on HCV for patients and practitioners ...

- Advances in Hepatitis C:
<www.adis.com/advances_hepc/>
- American Liver Foundation:
<www.liverfoundation.org>
- Hepatitis Branch, Centers for Disease Control & Prevention:
<www.cdc.gov/ncidod/diseases/hepatitis>
- Hepatitis Foundation International:
<www.hepfi.org>
- Hepatitis Information Network:
<www.hepnet.com>
- National Center for Complementary and Alternative Medicine:
<<http://nccam.nih.gov/>>
- National Center for Infectious Disease viral hepatitis data:
<www.cdc.gov/ncidod/diseases/hepatitis/index.htm>
- National Institute of Diabetes and Digestive and Kidney Diseases:
<www.niddk.nih.gov/health/digest/pubs/hep/>
- Organization to Achieve Solutions in Substance Abuse (O.A.S.I.S.):
<www.oasisclinic.org/>

Practice Pointers Continued from Page 5

able news!

With adequate methadone dose, and after a time of adjustment, patients find side effects disappear or become manageable. Here again, understanding family members can assist by emphasizing the need for a good diet with plenty of fibre, a reduced amount of refined sugar, and plenty of exercise. But, of course, this applies to the rest of us as well!

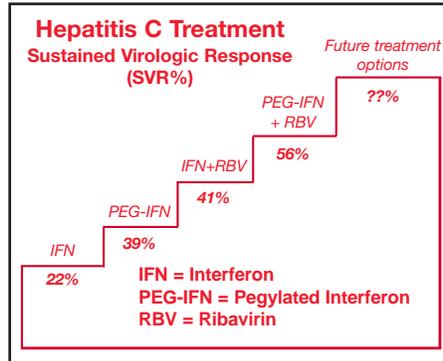
***Andrew Byrne, MD** is an addiction specialist working in the field for almost 20 years, with a clinical practice in inner Sydney, Australia. He is the author of *Addict in the Family: How to Cope with the Long Haul and Methadone in the Treatment of Narcotic Addiction*, as well as numerous journal articles.

A.T.E.

Liver Disease in MMT Continued from Page 1

ment, which some describe as a cure.[4]

The first treatment for HCV was interferon. Injected under the skin 3 times a week for 24 to 48 weeks, it produced an SVR of up to 22% (see graph). The addition of another medication called ribavirin, which is taken by mouth twice daily, led to a near doubling of response rates to 41%.[6,7]



More recently, a longer-acting interferon, called pegylated interferon, has been developed that only requires weekly injection. It is a more effective medication than standard interferon, leading to SVRs of 39% by itself and up to 56% when combined with ribavirin.[8-10]

Success Factors

The most important predictor of treatment response is a viral characteristic called genotype, a genetic variation that has been likened to a viral "strain." There are 6 major genotypes; in the U.S. genotypes 1, 2, and 3 are the most common, with most patients having type 1.[6]

Genotype does not affect the progression of liver disease, but it has a major impact on treatment outcome. Patients with genotypes 2 and 3 may show SVRs greater than 80% with pegylated interferon plus ribavirin, but response in those with genotype 1 is only about half that.[11,12]

Additionally, patients staying on therapy and taking nearly all of their medication have better treatment outcomes. [9,10,13] Other factors – such as age, sex, and extent of liver damage – also play a role.[14]

Although eliminating the virus is the main objective of HCV therapy, interferon may benefit the liver even in the absence of viral remission. Some studies have shown that it can slow progression of liver scarring and that it may reduce the risk of developing liver cancer.[15]

Unfounded Treatment Barriers

Even though injection drug use (IDU) accounts for the majority of HCV cases,

recovering IDUs on methadone maintenance are sometimes denied treatment for HCV and have been excluded from the majority of clinical studies of HCV treatments.[16] Although there is no relevant data, questions are often raised about their ability to tolerate treatment, potential relapse to drug abuse, comorbid psychiatric conditions, and possibility of reinfection.

In the general population, more than 20% of patients may discontinue HCV treatment due to intolerable side effects, including flu-like symptoms, fatigue, and anemia. Interferon can lead to severe depression, and uncontrolled depression or other psychiatric conditions usually exclude patients from starting interferon-based therapy.

An ongoing question is whether MMT patients should be withdrawn from methadone prior to HCV treatment. However, a review by Mattick and Hall [18] concluded that methadone provides stability in patients' lives, making them more receptive to adjunctive therapies. *They specifically recommended that patients need not be taken off methadone before undergoing other therapies.*

A small, prospective study in Europe by Schaefer [19] examined psychiatric complications during combination interferon/ribavirin therapy for HCV in MMT patients compared with control patients who were not former drug addicts. Depression increased equally in both groups of patients; however, the depression was mild to moderate in the methadone patients, whereas severe depression was experienced by a third of the controls. Withdrawals from treatment were equivalent in both groups; none due to depression.

Furthermore, methadone maintenance may slow the progression of HCV infection. An investigation of 285 HCV-positive IDUs [20] found that those in MMT programs were significantly less likely to develop chronic HCV infection than still-active injection-drug abusers. Furthermore, in those already chronically infected, methadone therapy was associated with more normal liver function, and methadone may allow the reversal of heroin-related immunologic impairment. Additional research is needed to better understand the natural history of HCV in MMT patients and the role of methadone in HCV treatment outcomes.

Research Supports MMT

In Schaefer's report, mentioned above, the response to interferon/ribavirin

Continued on Page 7

Liver Disease in MMT Continued from Page 6

therapy after 24 weeks was 50% in MMT patients and 39% in controls. Importantly, during anti-HCV treatment, MMT patients benefited from increased methadone doses.[19]

Blechman and colleagues [17] compared interferon therapy in MMT patients and in a control group of patients not on methadone. Disease severity, response to interferon, side effects, and treatment compliance were similar in both groups. The authors concluded that *MMT patients should not be automatically excluded from HCV-treatment trials and should be offered HCV therapy like anybody else.*

An ongoing series of clinical trials focusing on HCV therapies in MMT patients is being conducted at the Organization to Achieve Solutions in Substance Abuse (O.A.S.I.S.) in Oakland, CA, under the direction of Diana Sylvestre.[5,21,22] In a preliminary analysis of 57 MMT patients who had completed interferon/ribavirin treatment,[5] the overall ETR rate was 56%; which was comparable to results in non-opioid-dependent populations. Sustained response rates in Sylvestre's study are not yet available.

Occasional drug or alcohol use during this study produced only minor decreases in treatment outcome that were not statistically significant. However, patients using illicit drugs daily showed no virologic response at all to HCV therapy.

Interestingly, the response rate in MMT patients was unaffected by prior psychiatric diagnoses. However, by the end of treatment, 88% of subjects had received some form of psychiatric medication, primarily SSRIs, for depression. Forty-two percent increased their daily methadone dose by an average of 10 mg.

Only 22% of MMT patients discontinued from Sylvestre's study, compared with up to 21% in other studies. However, discontinuations were lower in MMT patients due solely to side effects.

Sylvestre concluded that tolerability, safety, compliance, and response rates in MMT patients were similar to those of historical controls (non-opioid-dependent patients) receiving identical therapy. This was evident despite substantial preexisting psychiatric comorbidity in the MMT patients, and the fact that they were older, and had longer histories of HCV infection along with more liver fibrosis than subjects in other studies. *Clearly, the stabilizing effect of MMT in these studies contradicts the need for pretreatment methadone withdrawal.*

Brighter Prospects

Prospects for MMT patients with HCV are looking brighter and an HCV "giant slayer" may be on the horizon. Sylvestre and her team at O.A.S.I.S. are continuing their research in MMT patients, using the newer pegylated interferon. Clinical trials at the San Francisco VA Medical Center also are enrolling methadone-maintained patients.

Future treatments may include anti-HCV agents that are especially useful in difficult cases. Pegylated interferon has demonstrated improved effectiveness, and a novel, bioengineered "consensus interferon" has shown promise in treating nonresponders. "Triple therapies" including an interferon in various combinations with ribavirin, mycophenolate mofetil, or amantadine have been explored.[11] Unfortunately, non-interferon-based regimens are not expected in the near future, so further study is needed to improve outcomes in difficult patient populations.

Use of complementary and alternative medicines by a third of patients with chronic liver disease has been reported. Silymarin (milk thistle) compounds are frequently mentioned, as are St. John's wort, ginkgo biloba, ginseng, garlic extract, and echinacea.[23]

Most of these agents are used in hopes of minimizing liver damage caused by HCV and to manage treatment side effects. However, the National Center for Complementary and Alternative Medicine is careful to note that "no complementary medicine or alternative medicine therapies have been scientifically proven to cure or even ease symptoms of hepatitis C." [24]

There is still the question of how MMT programs can participate in helping their HCV-positive patients get proper treatment. This will be addressed in the next article of this series.

AT Forum thanks Diana Sylvestre, MD (O.A.S.I.S., Oakland, CA) for her extensive contributions to this article.

1. Alter MJ. Hepatitis C: a sleeping giant? *Am J. Med.* 1991;91:1125-1155.
2. Wong JB, McQuillan GM, McHutchinson JG. Estimating future hepatitis C morbidity, mortality, and costs in the United States. *Am J Pub Health.* 2000;90(10):1562-1569.
3. Liver disease in MMT: treatment and transplant. Part 1: critical concerns. *AT Forum.* 2001;10(4).
4. Kjaergard LL, Krogsgaard K, Gluud C. Interferon alfa with or without ribavirin for chronic hepatitis C: systematic review of randomized trials. *BMJ.* 2001;323:1151-1155. Also, Lau DT, et al. 10-year follow-up after interferon-alpha therapy for chronic hepatitis C. *Hepatology.* 1998;28(4):1121-1127.
5. Sylvestre DL. Overcoming barriers to hepatitis C treatment. Presentation at American Methadone Treatment Association Conference 2001; October 8, 2001; St. Louis, Missouri.
6. Chronic hepatitis C: current disease management.

Bethesda, MD: National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). NIH Publication No. 99-4230, May 1999 (updated November 2000). Available online at: www.niddk.nih.gov/health/digest/pubs/chrnhepc/chrnhepc.html.

7. McHutchinson JG, Gordon SC, Schiff ER, et al. Interferon alfa-2b alone or in combination with ribavirin as initial treatment for chronic hepatitis C. Hepatitis Interventional Therapy Group. *N Engl J Med.* 1998;339(21):1485-1492.
8. Davis GL, Rodrigue JR. Treatment of chronic hepatitis C in active drug users. *N Engl J Med.* 2001;345(3):215-217.
9. Foster G. Comparing clinical trials. *Advances in Hepatitis C.* 2001;2(1). Available online at: http://www.adis.com/advances_hepc/issue_V211/FEA_Com.html.
10. McHutchinson JG, Manns M, Harvey J, Albrecht JK, for the International Hepatitis Interventional Therapy Group. Adherence to therapy enhances sustained response in chronic hepatitis C patients receiving PEG-interferon alfa-2b plus ribavirin. *J Hepatology.* 2001;34(Suppl 1):2-3.
11. Manns MP, Wedemeyer H. Hepatitis C infection - optimizing treatment, patient management, and basic aspects. *Medscape Gastroenterology* [online serial]. 2001;3(3). Available at <http://www.medscape.com>.
12. Sherman M and the CASL Hepatitis Consensus Group. Management of viral hepatitis: clinical and public health perspectives - a consensus statement. *Can J Gastroenterol.* 1997;11(5):407-416.
13. Fried MW, Shiffman ML, Reddy RK, et al. Pegylated (40 kDa) interferon alfa-2a (Pegasys®) in combination with ribavirin: efficacy and safety results from a phase III randomized, actively controlled multicenter study. *Gastroenterology.* 2001;120(Suppl 1):A-55. Abstract 289.
14. McHutchinson JG, Poynard T. Combination therapy with interferon plus ribavirin for the initial treatment of chronic hepatitis C. *Semin Liver Dis.* 1999;19(Suppl 1):57-65.
15. Gow PJ, Mutimer D. Treatment of chronic hepatitis. *BMJ.* 2001;323:1164-1167.
16. Stephenson J. Former addicts face barriers to treatment for HCV. *JAMA.* 2001;285(8):1003-1005.
17. Blechman MB, Charney JA, Friedman P, Clain DJ, Bergasa NV. Interferon-alfa (IFN- α) therapy in patients with chronic hepatitis C (CHC) on methadone. *Hepatology.* 1999;30:482A. Abstract 1287.
18. Mattick RP, Hall W. Are detoxification programmes effective? *Lancet.* 1996;347(8994):97-100.
19. Schaefer M. Psychiatric patients, methadone patients, and earlier drug users can be treated for HCV when given adequate support services. Presentation at Digestive Disease Week; May 20-23, 2001; Atlanta, Georgia.
20. Clarkston WK. Methadone therapy is associated with a reduced risk of chronic hepatitis C virus infection in patients who are positive for HCV antibody. Abstract and poster presentation (#241) at Digestive Disease Week 2000; May 21-24, 2000; San Diego, Calif.
21. Sylvestre DL, Aron R, Spencer L, Sellers A, Perkins MP. Safety, tolerability, and compliance with Rebetron treatment in recovering substance abusers on methadone; a preliminary retrospective analysis. In: *Eliminating Health Disparities. Abstracts of the 128th Annual Meeting of the American Public Health Association;* November 12-16, 2000; Boston, Massachusetts: 422.
22. Sylvestre DL. Treating hepatitis C in methadone maintenance patients: an interval analysis. *Drug Alcohol Dep.* 2002, in press.
23. Herrine S, Brown R Jr, Esposito S, et al. Pegylated (40 kDa) interferon alfa-2a (Pegasys®) in combination with ribavirin, mycophenolate mofetil (CellCept®), amantadine, or amantadine plus ribavirin in patients that relapse on Rebetron™ therapy: a preliminary report of a randomized, multicenter efficacy and safety study. *Gastroenterology.* 2001;120(Suppl 1):A-384. Abstract 1966.
24. Hepatitis C: Treatment Alternatives. NCCAM (National Center for Complementary and Alternative Medicine). 2000. Publication Z-04. Available online at: <http://nccam.nih.gov/fcp/factsheets/hepatitisc/hepatitisc.htm>.

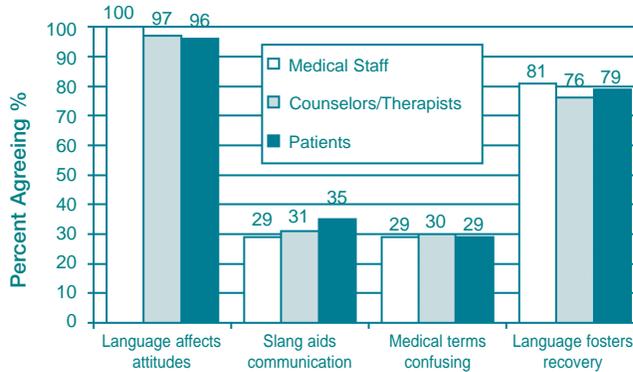
Survey Results - Talking to Patients

"What we have here is a failure to communicate." That most memorable line from the 1967 classic film, "Cool Hand Luke," characterized the nonconformist rebellious sentiment of the times.

In that spirit, the Summer 2001 edition of *AT Forum* (Vol. 10, No. 3) questioned how the use of language in MMT programs might today serve to hinder effective communication and separate the addiction treatment field from mainstream medicine. We surveyed readers, asking them to indicate agreement or disagreement with the following four statements:

1. Language affects attitudes and how patients feel about themselves.
2. Using slang aids better communication.
3. Medical terms would confuse patients.
4. Using proper medical language helps foster recovery.

There were 304 responses (60 medical staff; 130 counselors/therapists; 114 patients). The **graph** depicts a summary of those agreeing with each of the statements.



A Little R-E-S-P-E-C-T

Perhaps, equally important as the words used, is how they are communicated. A patient commented: "I don't care how the subject matter is presented, as long as the person doing it treats me with respect and understanding."

Admittedly, the use of certain slang terms can be comforting to some persons. However, when used to "put other people in their place," words become weapons. Terms like "junkie," "dirty urines," and even "addict," can be stigmatizing insults when used in clinical settings.

As one patient complained, "When I am spoken down to, which happens often, it affects my entire being."

Another wrote, "There's nothing wrong with speaking on the same level as the patient, but only when necessary and with respect and common sense."

Finally, a therapist optimistically asserted: "We are working with some of the most intelligent people on Earth and they should be treated like it! *Teach them; don't judge them.*"

A.T.F.

Compassionate Understanding

Responses were consistent across groups and suggest that readers favor better communications, using proper medical terminology. Most, but certainly not all, believed that slang is generally unhelpful and that patients would not find medical terms confusing. Similarly, readers largely agreed that language can be important in helping promote recovery and improving patients' perceptions of themselves.

Accompanying comments supported those beliefs. However, for the first time in an *AT Forum* survey, there were no written remarks from medical staff (physicians/nurses).

Most comments emphasized a need for compassionate understanding of individual patient needs and preferences for how information is communicated to them. A counselor wrote: "As professionals, we have a responsibility to educate our patients about appropriate terms, as well as medical effects of chemical dependency."

Another observed that some patients are not well educated and do not understand medical terms. However, almost all patients are interested in learning more about their disease of addiction and can be educated by clinic staff.

ADDICTION TREATMENT

Forum

is published quarterly by:

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

Editor: Stewart B. Leavitt, Ph.D.
Art Director: Julia Kim

© 2002 Clinco Communications, Inc.
Addiction Treatment Forum is made possible by an educational grant from Mallinckrodt Inc., a manufacturer of methadone and naltrexone. All facts and opinions are those of the sources cited. The publishers are not responsible for reporting errors, omissions or comments of those interviewed.

PRESORTED
STANDARD
U.S. POSTAGE
PAID
Arlington Heights, IL
Permit # 896