SSMR: Turning Failures Into Successes

The Lower East Side Service Center (LESC) was first started in 1959 and has become one of the largest non-hospital based substance abuse treatment centers in New York City providing a variety of patient and family services. In 1982, they recognized that a serious problem in all the methadone programs throughout the city was the numbers of patients who were at risk of being terminated from their outpatient status because of various problems that they experienced. Consequently, LESC developed their Short Stay Methadone Residence (SSMR) program which is the only short-term therapeutic community and methadone treatment program of its kind in the United States.

A.T. FORUM talked with Herbert Barish, CSW, Vice President of LESC and Ed Manches, Director of the SSMR program to learn more about their unique approach. According to Barish, “We developed this because it was important to have another service for patients not really doing well. We developed a phased program but we used a lot of brief therapy concepts in that people knew exactly when they were going to leave when they entered the door. We were different from the regular therapeutic community where you might be able to stay for a couple of years. Here people knew they were going to be out, at that time in 3 to 6 months, now it’s 6 months. We entered into contracts with various outpatient programs to accept their problem patients into our program only if the sending program accepted them back upon discharge.”

The 40 bed SSMR program is non-profit and funded by the state and

Forest Tennant: Controversial Champion of MMTP

Forest Tennant, M.D., Dr.P.H. is the founder and executive director of the Community Health Projects Medical Group and The Research Center for Dependency Disorders and Chronic Pain headquartered in West Covina, CA. The largest such group in the Western United States, they have 26 private dependency disorder and pain clinics in 21 California cities; 18 of those offer methadone maintenance treatment programs.

A.T. Forum: Dr. Tennant, what do you do differently than other clinics?

FOREST TENNANT, M.D., Dr.P.H.: Our clinics have traditionally been smaller, with more personal care of the addict. It’s important to note, however, that our facilities are low-cost clinics. They are not expensive.

We have championed here in California — and it used to be extremely controversial — making methadone available on a low cost fee basis. There simply isn’t enough public funding to go around. We have some public funding, but it only takes care of a small fraction of those who need and want help.

I think one of the major issues today is to get over what has been a terrible bias against private clinics. We have so many addicts who need help that there is no possible way we can finance all the addicts on a public basis. We cannot rely on insurance companies, or the Clinton health care plan, or anything else.

A.T.F.: We understand that you supplement methadone treatment with other agents and this has been controversial.

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The deadline for all MMTP Survey responses is September 15, 1993. Let us hear from you!

"Tennant" continued from page 1.

TENNANT: We are great believers in the use of vitamins, amino acids, minerals and other nutritional supplements for the methadone patient. One of the things that is not well appreciated about heroin addiction is that practically every heroin addict who gets sick enough to seek treatment could be legitimately diagnosed as being malnourished. One of the simplest and most effective things we can do with methadone treatment to make it work better is to provide some nutritional supplementation.

A.T.F.: Are there other controversial areas?

TENNANT: I was one of the people who popularized the use of antabuse in methadone programs to help stop people from drinking. I’ve also advocated for many years that a methadone patient should get a breath alcohol test once a week. That’s been controversial. Plus, any patient who has hepatitis and is thought to be drinking should not only have a breath alcohol test but should have a urine alcohol test. Urine alcohol is not routinely tested in methadone programs.

A.T.F.: Some private clinics have been criticized for wanting to keep addicts on methadone indefinitely. What’s your approach?

TENNANT: One of the other things that I’ve become known for being very controversial about is that I recommend addicts try to get off methadone when they’re ready. But, I have a set of goals that I think they should accomplish before they try to detoxify.

First, they’ve got to be totally drug free, and have stabilized their lives. And then they’ve got to check into a methadone clinic for another 30 days to be sure they can function. Then it’s time to seek a new direction.
AIDS & Innocence

"Please stop using the term 'innocent victims' when referring to AIDS related issues. This term implies all others are rightfully victims of this disease."

C. Sutton-DeBarros, R.N.,
Bronx, NY

[EDITOR'S NOTE: The writer was no doubt referring to the article in our last edition of A.T.F. (Vol.II, #1) entitled "Drugs, AIDS & Children: Orphans Innocent Victims of IVDLs." In this case, the healthy children were, indeed, innocent bystanders (victims) orphaned by consequences of the disease when their afflicted mothers died.

However, the writer's basic point is well-taken and important. The popular press, by often stating that certain persons contracting HIV/AIDS as a result of medical procedures or other circumstances beyond their control are "innocent victims," implies that all others are somehow guilty or deserving of their fates. The last thing we need associated with this dreadful epidemic is moralizing after the fact; it would only serve to hinder further research and compassionate treatment of still living patients.]

Locked-Out of "Medical Maintenance"

"As a Long Island Jewish Hospital methadone patient in excellent standing, I qualify for the 'Medical Maintenance' program presently at Beth Israel Medical Center. However, I was told two years ago that no new patients were being taken and nothing has changed since then. I would like for your readers to be aware of this methadone treatment modality. Perhaps, if more treatment personnel knew about medical maintenance they would urge the FDA to hasten the approval process to expand its availability. This program would be beneficial to long time patients, such as myself, and would open-up treatment slots for people on clinic waiting lists who are desperately seeking help, especially in light of the HIV/AIDS epidemic among IV drug users."

[Bayside, NY

[EDITOR'S NOTE: See follow-up story on medical maintenance in this issue.]

Symposium in California

Two City Tour a Big Success

Los Angeles [June 24] and San Francisco [June 25] were sites for two “Addiction Treatment Forum Symposiums.” The programs, attended by over 300 professionals, were endorsed by The California Department of Alcohol and Drug Programs and the Bay Area Addiction Research and Treatment/California Detoxification Programs, Inc. Funding was provided by an educational grant from Mallinckrodt Specialty Chemicals Company, St. Louis. During each day, four distinguished speakers addressed current topics relating to methadone treatment. Here are some highlights:

Beny J. Prim, M.D. [President of the Urban Resource Institute, New York City] stressed that addiction is a chronic relapsing disorder requiring a continuum of care for a lifetime. While methadone given in "adequate doses" can be an answer for many opiate addicts, "all treatment modalities are effective," he stated. Some treatments may be better than others for particular individuals, and there is a need to consider other factors like social and economic concerns, family issues, employment, housing, etc.

Prim called for a "Supermarket of Services" offering comprehensive care to meet individual patient needs. He stressed the need for same day intake of patients to get them off the street and into treatment. The HIV/AIDS threat has created a focus on drug treatment which has brought together the substance abuse and public health systems. "Drug abuse treatment must become part of the mainstream of medical treatment," he said, and patients should be treated in pleasant settings that will help maximize success. Counselors must be experienced, unbiased and dedicated to meeting their patient's needs: "They need to be there for the reason, not just the season," Prim stated.

Jerome Jaffe, M.D. [Associate Director, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration] addressed methadone dosage practices. While methadone is effective in reducing IV heroin use, he noted, patients do relapse when they stop treatment. However, he stressed that methadone should be viewed as a medication, just as are insulin, digitalis, antidepressives, etc. When the medication is discontinued, there are undesirable results. And, as with other medications, there are times when methadone dosage might need to be increased at least temporarily, such as during periods of stress or when the patient is taking medication that increases the metabolism of methadone.

Jaffe observed that too high a methadone dose can produce unwanted side effects, whereas too low a dose can result in patients continuing heroin use or dropping out of the program. Higher doses — 60, 70, 80 mg/day — have been found better in terms of less continued IV heroin use by producing cross-tolerance (reducing heroin's desired effects) and decreasing drug hunger. He noted that 60 mg/day seems to be a useful target dose in early stages of treatment and, after a period of stabilization, lower doses may be adequate for some patients, others, however, may need higher doses. It is important to reach a stable, adequate dose level or steady plasma state wherein the amount of methadone taken in each day replaces the amount excreted. However, plasma levels can be affected by individual metabolism rates and by other medications. These conditions may require dosage adjustments. It takes several days

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Political Perspective

A.T.F. talked with Richard Weisskopf, Methadone Treatment Liaison, Department of Alcoholism & Substance Abuse (DASA), State of Illinois to get his views of current trends from one state's perspective.

Regarding interim methadone treatment (see new CFR as reported in the last issue of A.T.F.) Weisskopf notes, "We have contacted the Illinois Methadone Treatment Providers Association and a strong majority is against interim maintenance." It could work, he believes, but the major question revolves around funding since this would bring more patients into the system without increased funds for staff and expenses. It would also place an added burden on methadone programs that are already overstressed and have waiting lists.

"Waiting lists are always troublesome," he observes. "We could certainly use more funding to get more people into treatment and to provide comprehensive services across the board rather than having to refer out of the system. I think that alcohol and substance abuse has always been an orphan child. It's not medical treatment; it's not social service treatment. It's been very difficult because, in effect, we're offering a specialty service and people don't quite know where to place us."

In Illinois there are 33 licensed methadone programs, and only a few of those are private. Weisskopf notes that, at the direction of DASA Director James Long, Illinois will be paying a lot more attention to methadone than in past years. "I think it's important to understand that in Illinois we probably are at the beginning of a new awareness of methadone," he says. "We have a Director who is willing to learn about methadone, to ask questions and seek answers."

Why is methadone suddenly becoming more of interest? "I think the obvious reason is probably the AIDS crisis. There's a lot of concern and that's where the interim methadone maintenance came from," says Weisskopf. "The problems surrounding intravenous drug users have got to be addressed. We have to see what works and what doesn't work and support what does. A lot of people think methadone treatment works."

Illinois has a history of being a so-called "low dose" state. Weisskopf explains, "When the old FDA rules called for initial doses of 15 to 20 mg's and maintenance doses not to exceed 30 to 35 mg's, Illinois went with that. Diversion was an issue, regulation was a big issue. The average dose in Illinois right now is just a little over 40 mg's."

New research suggests that higher dose regimens get results. According to Weisskopf, Illinois is pleased to see that research and they're going to work with the Illinois Methadone Treatment Providers Association to provide education, to make sure that the new State Methadone Guidelines put out by CSAT are reviewed, digested, discussed, and hopefully implemented. Those guidelines call for appropriate blocking doses of methadone at 80 mg — plus or minus 20 mg — that is, a 60 to 100 mg range. Weisskopf says, "It will take some time to educate the field in the new research and probably some people will be a little more difficult to convince. I think if [our providers] read the data, get the research, dosages will start going up and we'll probably see better treatment results."

Are there any conflicts in Illinois between the drug free factions as opposed to those who believe in the efficacy of methadone maintenance? Weisskopf admits there are different philosophies, just as there were differences between the alcohol and the drug treatment professionals before they became a consolidated department. "We have room for more than one treatment regimen or philosophy," he believes. "I would like to see treatment at all levels tailored to the needs of the patient rather than to have it fit into a single system or approach. The more treatment regimens we have available, the better off everyone is; patients and the public at large."
free for two or three months. But, if they have all of the other five goals put together I don’t care if it’s a month. Second, they’ve got to have a sound nutritional program. Three meals a day and appropriate nutritional supplement. For example, I don’t know that I’ve ever seen anybody get off methadone and stay off that couldn’t learn to eat a breakfast.

Third, they must have a solid financial base. In other words, a job or steady income to support themselves. Fourth, they need a social support system; a family, a home, transportation. Fifth, they must be free of legal hassles; not on probation or involved in a pending legal case.

Number six, we believe that major stress elements in their lives have to be resolved.

Once they can reach those six goals, I recommend everybody try to get off methadone. That’s controversial since some people believe that no one should ever try to get off methadone. I say they should try to get off, but I also say that the program needs to be ready to take them back at any time.

A.T.F.: Are you opposed to somebody being on methadone for a lifetime?

TENNANT: No. For a certain number of people that’s the kindest and best thing we could do. I’ve advocated that the programs need to be established so that a person can take methadone for six months, six years or sixty years. If they need to take it for a lifetime then that’s just fine.

A.T.F.: Who’s going to pay for such care?

TENNANT: We in the field who provide care need to make this treatment available on a low cost basis that the average person can afford. One of the issues we hear too much about in the drug field is the poor. Granted, a lot of addicts are poor, and they’re not working and are going to need public money. But we keep forgetting that the vast majority of drug addicts in this country are of the working class. If they are given an opportunity to obtain treatment at a reasonable cost, in a setting that they can relate to, they will come.

The bottom line is, we’ve got to get over this idea that we can take care of the thousands of people who are addicted on the public dole. If there is one boring bunch of rhetoric that I’ve heard over the years it’s from all the people who want to go to Washington and take on the new president, or take on a new governor, and tell them they’ve got to fund all of this. They can’t fund all this. The Clinton health care plan is not going to provide free methadone for life for every addict who wants it.

We’re the problem, not the government. We have to advocate for these patients. We can’t let a bunch of bureaucrats and politicians — people who have a bias about medical treatment — let drug addicts die. Or, let them infect and affect the community at large.

A.T.F.: Do you believe methadone sometimes suffers from an unjustifiably bad reputation?

TENNANT: Let me say this to our critics about methadone: I’ve dealt with methadone for over twenty years. Methadone was never meant to be a cure. It was never meant to be a blocker. It was really there as a holding pattern. If indeed we do find some therapeutic agents that will activate the pituitary-adrenal axis or neurochemical systems that control addiction, we can take people off methadone just as easy as off heroin, in fact a lot easier.

And so our critics need to understand that no one is holding back their cures. If we knew what else to do we’d do it. If you’ve got something else to offer somebody so they can come off of methadone, then I think it also needs to be tried. No one likes methadone until they realize what’s in second place. We need methadone treatment to be spread rapidly at this time.

[For more information about his programs, Dr. Tennant’s office may be contacted at 800/624-4540 (in CA 800/821-0775)]
SSMR continued from Page 1

third parties such as Medicaid, Home Relief and others. Additionally, they receive some small grants from foundations or donations. Most patients come from the New York City area and there is a waiting list. They currently have 30 men and 10 women, racially mixed (roughly a third each Caucasian, Hispanic and Afro-American). The average age is 33 to 35 years old. This overall mix is typical, according to Manchess.

"We are highly successful in returning people to their programs stabilized on methadone, almost to the person," notes Barish. "Even if they leave earlier, people go back to their clinics and they go back in fairly decent shape on methadone. Then there are other levels of success along the way."

Manchess adds, "Last year we admitted 144 patients, of which 63 stayed the entire 6 months; the ones that didn't complete the program were discharged due to inappropriate behavior. But even all of those people go back to their clinics more stabilized, more productive, better able to deal with life on a daily basis."

Barish observes that they have a high percentage of people who are HIV positive; approximately 30 to 35%. So, there is a significant amount of case management assistance that's required. "It takes a very dedicated staff who are skilled at not only working with substance abuse and mental health, but with AIDS," he says. "You need to assist all those patients who are not HIV positive in learning how to reduce their risk factors and to stay in the program without getting too nervous about the AIDS patients being around."

SSMR residents often present multiple problems and require a range of services to meet their medical and psychosocial needs. Clinical services include psychiatric consultation, individual vocational and educational counseling, as well as group therapy. Manchess notes there are 17 different support groups focusing on such issues as alcohol abuse, aftercare, women's issues and pre-vocational needs. Recreational activities are also stressed to assist residents in developing social skills.

Barish claims funding for the program has not been difficult because of their ability and proven successes. But, it is more expensive because it is a combined medical and therapeutic community model; versus what a straight therapeutic community might cost. However he notes, "It is far less than it would cost to incarcerate someone or to have them in a regular hospital for a year." As part of their success, a number of former patients are now counselors in other programs and some have become supervisors."

We believe that every state should have this type of resource available to them. Certainly, we have found it extraordinarily helpful to us in having this program and we think other states would benefit as well," Barish concludes.

For more information about the SSMR program, Herbert Barish can be reached at 212/233-5372.

Clinic Notes – Medical Maintenance

In response to a reader's comments regarding the methadone medical maintenance model [see "Feedback" in this issue], A.T. Forum contacted Nina Peyser, Executive Director of the Chemical Dependency Institute at Beth Israel Medical Center in New York, and Edward C. Senay, M.D. with the University of Chicago Department of Psychiatry. Both institutions have medical maintenance programs undergoing testing, although their approaches differ. In general, medical maintenance is the ongoing treatment by primary care physicians of rehabilitated methadone maintenance patients. The patients are stable, employed, not abusing drugs and not in need of the extensive support service typically offered in a clinic setting.

Beth Israel Extends Test

Nina Peyser indicated that Beth Israel has been part of a medical maintenance research project for the past ten years. It originated at The Rockefeller University, New York in June 1985 and was fully transferred to Beth Israel a few years ago.

According to her, "in a medical maintenance program, a methadone patient is treated like any other medical patient with a chronic disease. They make an appointment with their doctor, usually once a month, and they visit the doctor's office, not a clinic. The visit is however brief or extensive as appropriate. A urinalysis is done on each visit and the physician has a conversation with the patient. If everything is fine, the patient takes one dose of methadone in front of the physician and takes enough home to last until the next visit."

Over the years, the research program came under the supervision of various physicians. It had been going on for so long, and seemed so successful, that it became accepted by those involved as an established clinical treatment program. Thus, the research aspect was somewhat overlooked.

According to Peyser, "We requested that the FDA legitimize the program and give us a blanket exemption from the federal regulations so that we could continue and

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before the full effect of any methadone dose increase or decrease is established.

Loretta P. Finnegan, M.D. [Senior Advisor on Women’s Issues, National Institute on Drug Abuse, National Institutes of Health, Department of Health and Human Services] focused on the treatment of pregnant opiate addicts and passively exposed neonates. Pregnant addicts, she observed, have a host of medical problems: poor nutrition inducing anemia, sexually transmitted diseases, tuberculosis, urinary tract infections, ulcers or infections due to needle use, and HIV are some. For the fetus, intra-uterine death, miscarriage, growth retardation or premature birth is more likely in opiate addicted women.

Finnegan expressed the view that, for pregnant opiate addicts, methadone’s benefits outweigh any risks in terms of: getting the patient into treatment; providing counseling, prenatal care, and better nourishment; and normalizing her life to deal with a child. There is a better chance that the child will be born at full term via a normal delivery and at a better birth weight. Sixty percent of babies exposed to methadone will have withdrawal symptoms. However, these are transient and afterward the children have normal development if raised in healthy environments.

For new patients coming into methadone treatment, Finnegan recommends a several day hospital admission for medical evaluation and stabilization on methadone. For existing methadone patients, there is no need to reduce the dose during pregnancy and an increased dose may be needed during the third trimester. It is important to prevent withdrawal in the mother so the fetus does not experience the stress. However, some symptoms of pregnancy may be confused with withdrawal, so close monitoring is advised.

Finnegan stressed that there is a need for close cooperation in treating pregnant addicts. These women need a team of individuals working together, sharing information to address medical, social, psychological issues. She also emphasized that the problems are definitely not limited to minorities. In that past, the statistics have been skewed because certain groups of addicted women were treated privately or never questioned about their use of drugs.

Tom McLellan, Ph.D. [Scientific Director of the Penn-VA Center for Studies of Addiction] spoke about the role of psychosocial enhancements to methadone treatment. He described a study which sought to determine the impact of counseling and other services in successful methadone treatment. Patients were randomly assigned to one of three groups: 1. methadone alone (at 60 mg/day minimum); 2. methadone plus counseling; 3. methadone plus counseling plus adjunctive services (medical, psychiatric, family counseling, employment assistance, etc.).

In terms of fewer drug-positive urines, the third group (comprehensive care) did the best, followed by the second group. The first group (methadone alone) had 55 to 65% positive urines and, in fact, 69% of patients in that group were terminated from the study due to at least 8 positive urines in a row during the first 12 weeks of treatment. Just by adding a counselor for the drop-outs, there was an improvement in their performance (as measured by a reduction in positive urines).

McLellan also reviewed a study which compared methadone plus a counselor versus methadone plus counseling plus one of two types of psychiatric therapy. While counseling plus therapy was better than counseling alone, patients without prior psychiatric symptoms or those with anti-social behavior problems did not benefit greatly from the psychiatric therapy component.

McLellan observed that the studies revealed that individual patient success in methadone programs is highly dependent on the skill of the counselor and/or therapist. The counselor is an “active ingredient” in treatment success, and the wrong counselor can actually be harmful. Good counselors are professional, trained and genuinely interested in helping substance abusers.

The counselor is an “active ingredient” in treatment success, and the wrong counselor can actually be harmful. Good counselors are professional, trained and genuinely interested in helping substance abusers.

A.L.F.

Continued from Page 6

expand the medical maintenance model. We had New York State’s support for doing this because their regulations had to be waived as well.” However, the FDA was concerned that the research had been neglected during recent years and felt it would be premature to issue a blanket exemption. The FDA did issue an extension so that the research could be activated and continued.

There are now 100 patients in medical maintenance at Beth Israel, but the program is closed to new admissions. “The FDA asked us to develop an additional research protocol that would add a few clarifications to the data that has been collected over the past ten years,” said Peyer. “This would be a short term process that could lead to a full exemption. At that stage, other programs can apply under similar rules and there could be more widespread expansion.”

Beth Israel also has an in-between phase called “after care.” This is at the clinic, not a doctor’s office, and is a pilot project with FDA approval. It requires clinic visits only every two weeks and is for patients who have been in treatment a long time and no longer need extensive support services.

Peyer believes such programs would be very welcome in other parts of the country. “Remember, most of the country has waiting lists,” she notes. “This is a way to open up treatment slots.” However, there are some patients who have declined to go to after care or medical maintenance because they like their clinics and they want to keep in touch with them. The programs are strictly voluntary.

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**Chicago Model Accelerates Entry**

According to Edward Senay, M.D., the New York model requires 5 years of successful performance in methadone maintenance before patients become eligible for the medical maintenance approach. "In this age of AIDS, I decided to try to replicate their findings and also to shorten the time of successful performance required to make people eligible for this concept," he said.

The Chicago model, started in June 1988, requires only 6 months of good performance in a traditional methadone maintenance program before a patient is eligible. Senay has a National Institute on Drug Abuse research grant to support the research. "In our 5 years of operation, we probably have studied about 250 to 300 people," he noted. The results are that roughly 75% of patients who are successful at 6 months will be successful a year later. And a substantial number of those, 70% to 80%, are successful for years.

In Chicago, patients report to the clinic twice a month and they must have one counseling session, one doctor visit, and one urine test per month. To control for possible diversion every patient receives a random call from the clinic nurse once each month. "Within 24 hours they must come in and show the bottles they have so that we know they still have the requisite number of remaining bottles," Senay stated. The frequency of clinic visits and diversion control measures were part of the negotiated research contract.

According to Senay, if they get the funds to complete the research — they need another 2 or 3 years to acquire a larger sample — he's hopeful of establishing the program as a permanent treatment modality. However, the study will end at the end of this August unless further funding is approved.

Patients involved report that it improves their ability to function because the demands of treatment are lowered, they feel more trusted, and they are able to devote time to their families and jobs. Senay emphasized that the patients in his program have low rates of HIV infection (1% to 2%), much like the rate in the general population.

Non-participant IVDUs exhibit 10 times the rate of HIV. He believes those who succeed in a medical maintenance program represent a special population of drug addict, and that such an approach would be applicable to only about 15% to 20% of all patients currently in methadone treatment.

As part of his study protocol, Senay uses matched control groups of patients who remain in standard treatment programs. He has found that patients in the experimental condition do as well as those in the control condition. So reducing services for this population of patients via medical maintenance doesn't seem to have negative effects. Also, he noted, "In 5 years of operation we know of only 3 criminal events among our total group during that time of nearly 300 patients. That's fantastic for former narcotics addicts."

A final point, added Senay, is that his medical maintenance approach saves money. "If people only have to pick up twice a month, rather than twice a week, that's a substantial savings in nursing time. If people only have one counseling session a month versus a session every week or two weeks, that's also a substantial savings."

Senay said he has a paper coming out this fall in the Journal of Addictive Diseases offering a preliminary report of his results. Reprints will be available by contacting his office at 312/702-6185.

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