

# FORUM ADDICTION TREATMENT

A Collaborative Initiative for Patients and Clinical Professionals

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## Managing Alcohol Use Disorders in OTP Patients Part II: Policy and Treatment Considerations

Patients' alcohol use is a major concern in opioid treatment programs (OTPs). Because alcohol is a legal, readily available substance, many patients consider its use acceptable, and many continue to use it during methadone maintenance treatment—some to the extent that calls for treatment intervention. Alcohol use can complicate patients' treatment outcomes and jeopardize their safety. It can also negatively impact patients' families and communities.

Part II, the concluding article in our series on patients' alcohol use, discusses alcohol policy, risk management considerations, and treatment and counseling options for managing alcohol use disorders (AUDs)

### The Importance of Developing Alcohol Use Policies and Protocols

Although there are no consensus guidelines covering patients' use of alcohol, and no mandates to treat AUDs, every OTP should have a written policy on dosing, monitoring, and treatment procedures involving alcohol use. Some programs do not allow any alcohol use; others regard managing alcohol use as a part of the treatment process.

Policies should recognize the importance of keeping patients who are in medication-assisted treatment (MAT) working toward positive outcomes—ideally, abstinence from all substances of abuse.

The OTP needs to consider its policy toward the occasional use of alcohol, such as one glass of wine with dinner several times a week, by a patient who is productive, misusing no medications, and using no illicit substances. The Code of Federal Regulations 42 CFR



Successfully treating OTP patients who have AUDs requires a multi-disciplinary approach, including drug therapy and behavioral interventions, involving all OTP staff.

Part 8 standard for methadone take-homes specifies the absence of recent *abuse*—not *use*—of drugs, including alcohol.

With policies in place, an OTP will be ready to respond to situations arising when patients with AUDs visit the clinic.

- A patient arrives smelling of alcohol. How often do you test a patient with a breathalyzer? Is a protocol in place for responding to breathalyzer scores? Some protocols rule out methadone dosing after a positive result. Some postpone or withhold the methadone, or give a partial or regular dose, depending on the breathalyzer score. Only a very few clinics dose the patient as usual, regardless of the breathalyzer results, to maintain a stabilizing blood level of methadone (see *Alcohol or Benzodiazepine Use in Patients on Methadone Maintenance: Is It Safe?* on page 5).
- A patient arrives, belligerent and obviously inebriated. Such patients cannot be allowed to drive home. What does the protocol recommend?

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# EMPLOYMENT OPPORTUNITIES

## How to Help OTP Patients Look for Work

Patients in opioid treatment programs (OTPs) who want to work but haven't had a job recently—or perhaps ever—face challenges, especially in today's economy. OTPs should help patients in their quest for employment. That assistance will also help patients in the process of recovery, according to two experts interviewed by *AT Forum*.

Discussions about getting a job should begin at the onset of medication-assisted treatment (MAT), even if the patient isn't ready to work yet, says Donna M. Coviello, PhD, research assistant professor at the University of Pennsylvania. "I know that goes against what patients are told in some OTPs—that they first need to be drug-free (except for methadone) for a certain amount of time," she says. "But there's a lot they can do to get ready." They need to start getting in the right mindset for work immediately, because it gives them hope and self-direction. They can go to the library to research jobs, training programs, and schools, for example. And they can start the process of scheduling their day around work hours.

This doesn't mean OTPs should be job-finding agencies. "The individual has to do the resource-finding," says Dr. Coviello, who conducted research in three Philadelphia-based clinics. "Show them they can be successful if they take action." Many patients come into treatment with low self-esteem, and a feeling that "nothing I do matters."

Belinda Greenfield, PhD, State Opioid Treatment Authority (SOTA) for New York, agrees. OTPs in New York are not mandated to have official vocational rehabilitation programs in place, but they are required to "work on the individual's educational and employment goals," Dr. Greenfield says. "If you can't provide for those services on site, you need to refer patients to community programs."



**Many OTP patients may not be ready yet for immersion in the work world. But knowing that it's a possibility can motivate and empower them, not only for employment, but for continued recovery.**

Dr. Coviello, who conducted research on employment issues in Philadelphia-based OTPs, says it's important for patients to determine their own goals. If they want to go back to school—often a first step towards a job—the counselor needs to help them figure out how to pay for it.

### Overcoming Barriers to Working

Unfortunately, even for patients who are stable and motivated, there are many barriers to employment. One of the main issues is potential drug testing, says Dr. Greenfield, who is also director of addiction medicine and self-sufficiency treatment services for the state's Office of Alcoholism and Substance Abuse Services. "Patients who are being maintained on methadone will have to divulge it, and their addiction history, if they know they will be tested." The OTP needs to help by providing a reference to the potential employer. "OTPs should also work with the business community, providing education about methadone and paving the way for patients to get jobs," says Dr. Greenfield.

Another barrier is financial: patients are afraid that if they get a job, they may lose their medical assistance. For many, that means they have no way of paying for their treatment. That's why it's important

**"Patients who are being maintained on methadone will have to divulge it, and their addiction history, if they know they will be tested."**

for OTPs to offer a sliding fee scale, keeping in mind that some patients will need to pay for transportation to the clinic, as well as paying for methadone treatment.

Dr. Coviello's research counselors told patients to find any job they can at the beginning. These jobs can lead to better ones that will include benefits, such as health insurance.

Patients who don't have take-home privileges face another barrier: how to get their methadone medication and arrive at work on time. OTPs should open at convenient hours to facilitate treatment and employment. Even patients with take-homes risk losing their jobs if their clinic schedule makes them late for work a few times.

### Adjusting to the Work World

Work is a "totally different world for some patients," says Dr. Coviello. Counselors need to go through the basics, like "How will you wake yourself up in the morning?" And once a job does start, the OTP needs to provide continued support and education. Patients need to be reminded, "If you're going to be out sick, you need to call in."

It's important for OTPs to support patients once they get a job, agrees Dr. Greenfield. "There's a lot of anxiety, and our patients don't understand the work environment. If you're not used to the structure of the world of work, you could get frustrated and quit."

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## Hire Your Patients

According to Dr. Coviello, many jobs are found by word of mouth, or by talking to people in methadone support groups.

Finally, patients shouldn't discount the possibility of employment in their own clinic—starting as an intern. Dr. Greenfield knows a patient who is now a manager in the OTP system in New York. She started at the bottom and went up through the ranks.

According to Dr. Greenfield, OTPs have few counselors who were or who are currently methadone patients. "I've framed this as a career path for our patients. Why shouldn't they be trained as counselors?" Drug-free treatment programs train patients to be counselors if they have the aptitude and the desire to help others. They've done this very well, but the OTP system hasn't.

Many OTP patients may not be ready yet for immersion in the work world. But knowing that it's a possibility can motivate and empower them, not only for employment, but for continued recovery.

**Sue Emerson, Publisher**  
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## Q&A

Questions & Answers

### Employment Discrimination Against Patients in MAT

#### Question

I am a patient in medication-assisted treatment for opioid addiction, and I want to begin looking for a job. A friend told me that some companies refuse to hire patients being treated for addiction, or they require them to taper their medication as a condition of employment. Is that legal?

#### Answer

Private employers with 15 or more employees and state or local government employers must comply with the Americans with Disabilities Act (ADA). Federal government employers and private employers who receive federal funds also must comply with the Rehabilitation Act.

Companies may not single out people in medication-assisted treatment (MAT) and require them to stop taking legally prescribed medications. Employers may, however, require people in MAT to provide documentation from their opioid treatment program (OTP) in order to explain why methadone or buprenorphine appears in a drug test.

If an employer requires you to stop taking your prescribed methadone, the Legal Action Center, a public interest law firm that works closely with MAT providers and patients, recommends that the OTP advocate on your behalf.

Ask your OTP to contact the person imposing this discriminatory condition. The medical director or administrator, not the counselor, should make the contact, asking why medication withdrawal is required. Ask if it is company or department policy, and if the policy is written or unwritten. A letter from the medical director to the employer is critical, and it must document patient progress and stability, the need for continued treatment, and the medical consequences of forced withdrawal. The letter should also include a clear statement that singling out an applicant is a violation of the law.

Sometimes this advocacy does not work. When this is the case, the Legal Action Center advises that the only solution is to file a formal legal case charging a violation of anti-discrimination laws. For more information about filing a lawsuit or other complaint, contact any or all of the following: the National Alliance for Medication Assisted Recovery ([www.methadone.org](http://www.methadone.org)), Faces and Voices of Recovery ([www.facesandvoicesofrecovery.com](http://www.facesandvoicesofrecovery.com)), your local or state bar association, and your city or state human rights agency.

Source: The Legal Action Center [http://www.lac.org/doc\\_library/lac/publications/Educating\\_about\\_Methadone.pdf](http://www.lac.org/doc_library/lac/publications/Educating_about_Methadone.pdf).

#### **National Association of Addiction Treatment Providers (NAATP) 2010 Annual Conference**

May 22-25, 2010

San Antonio, Texas

Contact: [www.naatp.org](http://www.naatp.org)

#### **American Psychiatric Association (APA) 163rd Annual Meeting**

May 22-26, 2010

New Orleans, Louisiana

Contact: [www.psych.org](http://www.psych.org)

#### **The European Opiate Addiction Treatment Association (EUROPAD) 9th European Conference**

May 28-30, 2010

Zagreb, Croatia

Contact: [www.europad.org](http://www.europad.org)

#### **The College on Problems of Drug Dependence (CPDD) 72nd Annual Meeting**

June 12-17, 2010

Scottsdale, Arizona

Contact: [www.cpdd.vcu.edu](http://www.cpdd.vcu.edu)

#### **COMING THIS FALL...**

#### **American Association for the Treatment of Opioid Dependence, Inc. (AATOD) National Conference**

October 23-27, 2010

Chicago, Illinois

Contact: [www.AATOD.org](http://www.AATOD.org)

Events to Note



(continued from page 1)

- A patient arrives, obviously inebriated, but docile. Some OTPs send the patient home in a taxi without dosing. Others keep the patient in the waiting room until breathalyzer scores are low enough for at least a partial dose of

methadone. But what about the morale of other patients nearby, waiting to be dosed? How will they react to this disruption? How does this situation impact the OTP's goal of maintaining a recovery-oriented atmosphere, rather than one that is disruptive to the recovery process?

- And what about the chronically intoxicated patient who does not respond to counseling? Discharge does not lead to positive change, but when the medical director considers discharge necessary, staff should always try to help the patient find an appropriate level of care, or a different treatment program.

### Treating AUDs in OTP Patients

AUDs are a complex problem; social, physiological, and medical issues are involved, and treatment must be individualized. The most effective approach combines medical and behavioral intervention—drug therapy, counseling, and lifestyle changes. A collaborative staff effort is needed to successfully treat patients with AUDs.

#### Approved Prescription Medications for AUDs in OTP Patients

The first consideration in selecting drug therapy is setting treatment goals consistent with OTP policy and patient motivation. If the patient agrees to reduce but not eliminate alcohol intake, staff may accept that decision, or set abstinence as a long term treatment goal. (The two FDA-approved medications for treating AUDs in OTP patients, listed below, are inappropriate if the patient is unwilling to stop drinking, but counseling remains an option.)

- Disulfiram (Antabuse), approved by the Food and Drug Administration in 1951 for treating alcoholism, does not reduce craving for alcohol, but prevents the body from eliminating a chemical that causes hangover symptoms. Taking disulfiram within 12 hours of drinking alcohol causes unpleasant symptoms and a severe, long-lasting hangover. Disulfiram is most effective when dosing is monitored by a family member or clinic staff to ensure patient compliance.
- Acamprosate (Campral) acts by reducing craving for alcohol. Treatment should begin as soon as possible after alcohol cessation.

Naltrexone is used also for the treatment of AUD, but is *contraindicated* in patients taking any opioid medications.

#### Behavioral Interventions Can Be Effective

OTP staff can use recent findings to explore ways to help patients. For example, a study found that patients' expectations of their own ability to change, and their expectations of their treatment outcome, are clues to the eventual result of therapy. What patients expect about their future cravings and drug use can be assessed routinely during counseling.

The preliminary study from Britain cited in Part I of this series listed patients' reasons for drinking—relieving boredom, relaxing, improving their mood, and forgetting problems. OTP staff can help patients find better ways than using alcohol to accomplish these goals. Staff can also motivate patients and communicate the importance of changing their behavior. The study found that if "important others" (such as therapists) strongly believe that patients *should* change their drinking behavior, patients expect that they *will* change.

Behavioral interventions are an important component of treating AUDs. Group counseling offers many advantages; group interactions reduce patients' feelings of isolation and allow patients to participate in the recovery of others.

- **Motivational Enhancement Therapy (MET)** – an evidence-based practice, MET attempts to motivate patients to change their behavior; it focuses on accepting personal responsibility and using personal resources
- **Cognitive Behavioral Therapy (CBT)** – another evidence-based treatment, CBT focuses on managing thoughts about alcohol and cravings, and avoiding situations that might lead to a relapse
- **Contingency Management Therapy (CMT)** – uses the principle that rewarded behavior is likely to be repeated; counselors award privileges or vouchers for such events as favorable laboratory test results

Counselors should also encourage patients to participate in outside support groups, such as 12-step programs (eg, Alcoholics Anonymous or Methadone Anonymous) or programs where successful patients help others reach goals of sober living. In addition, sober housing units or similar facilities can help transition OTP patients to healthy lifestyles.

#### The Importance of Patient Education

Staff can be especially effective in educating if they provide information targeting each patient's specific areas of alcohol risk:

- Ways that alcohol aggravates hepatitis infection
- Dangers to the brain from binge drinking
- Alcohol-related damage to the liver and brain
- General information on the dangers of excessive alcohol intake, especially in methadone patients
- Alternate ways to cope with stress (eg, relaxation techniques)

An abundance of information and pamphlets can confuse and overwhelm patients.

Successfully treating OTP patients who have AUDs requires a multidisciplinary approach, including drug therapy and behavioral interventions, involving all OTP staff. A well-planned written policy helps staff respond quickly, appropriately, and consistently to situations at the clinic, while safeguarding patient safety. OTP policies must allow for individualized treatment plans and goals, periodically modified, consistent with patient needs. Staff need to share the policy with patients and their families, so patients know what to expect at the OTP, and what the OTP expects of them.

*The online version of this article, available at [ATForum.com](http://ATForum.com), provides links to helpful resources on behavioral intervention, medications, and other information on treating AUDs in OTP patients.*

# Alcohol or Benzodiazepine Use in Methadone Patients: Is It Safe?

If a patient is stable on and tolerant to a maintenance dose of methadone, and has one alcoholic drink,\* or takes a therapeutic, prescribed dose of alprazolam (Xanax) for panic disorder, would the combined effects cause a dangerous reaction? In either case, would the patient experience any greater effect from the drink or the therapeutic dose of alprazolam than would someone not on methadone? At what point—if any—do central nervous system (CNS) depressants have adverse effects on patients in opioid treatment programs (OTPs)? In January, *AT Forum* asked experts these questions, and found that in general, tolerance to a methadone dose means patients are not at increased risk when taking other CNS depressants—provided that the amounts of the other CNS depressants are not excessive.

There is no scientific evidence that people on stable doses of methadone shouldn't have a cocktail or be prescribed a therapeutic dose of benzodiazepines, experts told *AT Forum*. The key is that the patient be tolerant to and not sedated by their methadone dose.

"We carried out many, many studies to address this, early on—whether or not any other CNS depressant potentiates the effect of methadone," says Mary Jeanne Kreek, MD, Head of the Laboratory of Biology of Addictive Diseases at The Rockefeller University in New York City. "The answer was absolutely not, until you got to very high doses of benzodiazepines or excessive amounts of alcohol."

Dr. Kreek's studies showed that "a normal social amount" of alcohol would not affect the patient who is tolerant to methadone, any more than it would affect someone not taking methadone. This amount is no more than two or three drinks or maximally, four, she says.

Benzodiazepines—again, not in excess—also are safe. "A normal therapeutic dose of a benzodiazepine is not going to cause CNS depression in a stable OTP patient," says Dr. Kreek.

## Tolerance Makes a Difference

For an opioid-naïve person, or a patient who is new or recently induced, and therefore not yet tolerant to or stabilized on methadone, combining methadone and other CNS depressants could be extremely dangerous. "If someone is opioid-naïve, takes even a small amount of methadone, and then drinks a glass of wine, the effect would cause the person to become sedated," says Ivan Montoya, MD, acting deputy director of the Division of Pharmacotherapies and Medical Consequences of Drug Abuse at the National Institute on Drug Abuse (NIDA). Slight increases could even cause overdose in the opioid-naïve patient. But there's no important additive or synergistic effect for someone stabilized for years on a methadone dose, he says.



## Should Methadone Doses Be Withheld?

Arriving at an OTP intoxicated on alcohol probably means the patient will have to wait a couple of hours before getting a full dose of methadone.

5

Clinicians who work with patients in medication-assisted treatment (MAT) prefer to "err on the side of caution," says Herbert Kleber, MD, professor of psychiatry at Columbia University in New York, where he is director of the division on substance abuse. Dr. Kleber, who developed the methadone program at Yale more than 50 years ago, strongly advises against giving methadone to a person who is intoxicated—not because there's scientific proof that it should not be done, but because "it's better to be safe than sorry—one always has to worry about the behavioral toxicity secondary to the alcohol intoxication."

Dr. Kreek also agrees that intoxicated patients should not be given methadone immediately. "We recommend the patient be observed and not medicated until two hours later."

There's usually an interior waiting room where patients can sit and watch videos while waiting for the alcohol to wear off, says J. Thomas Payte, MD, medical director of the OTP chain Colonial Management Group. "When we see someone who is oversedated, we don't know if the levels are going up or coming down," he says. Sometimes patients receive a partial dose, and the remainder a couple of hours later.

**There is no scientific evidence that people on stable doses of methadone shouldn't have a cocktail or be prescribed a therapeutic dosage of benzodiazepines.**

Edwin A. Salsitz, MD, addiction medicine specialist at Beth Israel Medical Center in New York City, would never give methadone to a patient who was intoxicated or sedated, if for no other reason than the patient might drive a car and cause an accident—with the chart clearly showing that the patient was given methadone (and the post-accident breath test showing a high level of alcohol). "There are legal reasons to worry about that," says Dr. Salsitz.

## The Importance of an Adequate Methadone Dose

Still, Dr. Payte is concerned that some people may "overreact because of this theoretical additive effect." Alcohol or benzodiazepine use may indicate that a patient is not receiving an adequate methadone dose. "But people are afraid to raise the methadone dose, even if it's indicated clinically, because of the bogeyman of interactions."

In fact, patients may be using alcohol or benzodiazepines in an attempt to "boost" the methadone dose, says Dr. Kreek.

## The Need to Treat For All Substances of Abuse

Dr. Salsitz questions whether someone with opioid dependence should drink, even in small amounts. Patients might get a slight "buzz" from alcohol—just as anyone would—and it might remind them of the days when they were using heroin and drinking, and lead to a relapse,

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**For an opioid-naïve person, or a patient who is new or recently induced, and therefore not yet tolerant to or stabilized on methadone, combining methadone and other CNS depressants could be extremely dangerous.**

he says. “It has nothing to do with synergy, it’s the risk of relapse.”

NIDA’s Dr. Montoya chastises OTPs that would treat someone with methadone for opioid addiction, but ignore their problems with benzodiazepines or alcohol. “You have to look at the signs and symptoms of the disease, and one of the symptoms is polysubstance abuse,” he says.

Dr. Kleber agrees that it’s important to treat the whole patient. “Programs are trying to help the patient lead the best life possible,” he

says. But it’s also important not to lose sight of the fact that methadone is designed to treat opioid dependence—period.

An across-the-board ban on alcohol or benzodiazepines for all patients in MAT is not appropriate. But it’s also wrong to think patients on methadone can consume addictive substances any more safely than other people in recovery. And using excessive amounts of CNS depressants with methadone—even if the patient is tolerant to the methadone, and completely stable on it—is very dangerous, leading not only to sedation but possibly to an overdose as well, says Dr. Montoya.

If there is any doubt about whether an individual can limit alcohol consumption to two or three drinks, or take benzodiazepines only as prescribed, the risks from any interaction with methadone are too great.

\*One drink is defined as 5 ounces of wine, 12 ounces of beer, or 1.5 ounces of distilled spirits. According to the National Institute on Alcohol Abuse and Alcoholism, more than 4 or 3 drinks a day or more than 14 or 7 a week constitute risky drinking for men and women, respectively.

## OTP VOLUNTARY MORTALITY REPORTING UPDATE

### AATOD Issues Advisory/CSAT Says Not All Data Are Required



On March 1, the American Association for the Treatment of Opioid Dependence (AATOD) joined the federal government in calling for voluntary death reporting of all patients in medication-assisted treatment (MAT).

“In our collective judgment, it makes sense for opioid treatment programs (OTPs) to submit such data to the Center for Substance Abuse Treatment (CSAT), especially since a significant number of programs already report deaths to their state authorities,” says AATOD President Mark Parrino. “While this may add some burden in terms of double reporting, we believe that it is important to have a central repository of such data as a means of further demonstrating that the clear majority of deaths due to the use of methadone lie outside of our treatment system.”

Some OTPs are taking a closer look at the forms and have questions about the level of detail required.

*AT Forum* talked with Robert Lubran, CSAT’s director of the Division of Pharmacologic Therapies, to get clarification on what is really needed to “comply” with the voluntary mortality reporting, and how the form might be changed in the future.

Many OTPs want to report deaths, because they think the objective of the reporting program is to show that most people in OTPs who die do

not die from overdoses—and that is indeed part of the reason CSAT is calling for the reporting, says Mr. Lubran. But the form is too complicated, and may actually discourage reporting, some OTPs say. Mr. Lubran’s response: “Nobody should feel that because there is information they don’t have, they shouldn’t send in the information they do have.” The psychiatric diagnosis information, for example, doesn’t need to be there if it’s not relevant to the death, he says.

There is also a question about what state of remission the person was in at the time of death, with boxes for “early remission,” “partial remission,” or “full remission.” While “controlled environment” means jail or prison, Mr. Lubran was unclear about the definitions of other categories, and said these will likely be eliminated in the future. The answers to these “category” questions are not critical to the form, for now.

There is still no universal definition of a methadone overdose that applies across all states, although CSAT is working on a draft report with suggestions for medical examiners. “We would like a national standard,” says Mr. Lubran. Until then, the death reports from OTPs will likely show that most deaths are not related to overdoses, but most often to liver disease, cancer, cardiovascular conditions, and other causes.

**“...it is important to have a central repository of such data as a means of further demonstrating that the clear majority of deaths due to the use of methadone lie outside of our treatment system.”**

The AATOD advisory can be accessed at: <http://www.aatod.org/policystat.html>.

To submit a mortality report to CSAT, go to <http://dpt.samhsa.gov/>, click on “Submit an OTP Mortality Report to SAMHSA,” and follow the instructions on the page, including links to the form <http://dpt.samhsa.gov/pdf/OTPMortalityForm.pdf> and the instructions [http://dpt.samhsa.gov/pdf/OTPMortalityForm\\_Instructions.pdf](http://dpt.samhsa.gov/pdf/OTPMortalityForm_Instructions.pdf).

## OTP Advocates Rally Against Restrictive NY Siting Bills



Legislation under consideration in New York would relocate opioid treatment programs (OTPs) that are within 500 feet of a secondary or elementary school, a day care center, or a place of worship, unless they are located within a hospital. Both lead sponsors are Democrats from Brooklyn, Alan Maisel in the Assembly and John L. Sampson in the Senate. Brooklyn is a part of New York City that includes many OTPS, schools, and places of worship.

The proposed legislation, which applies to existing and new OTPs, is “a common-sense solution that ensures people get the treatment they need without creating a burden or a potentially dangerous situation for local community residents,” said Austin Shafran, spokesman for Senator Sampson, citing in particular loitering and vandalism.

**“This bill flatly violates the Americans with Disabilities Act (ADA), which prohibits discrimination based on disability.”**

However, it’s unlikely that the proposed legislation will ever get to the floor, thanks to an immediate response from the OTP community, which strenuously defended their patients. “This goes beyond ‘not in my backyard (NIMBY);’ this is ‘NOPE (not on planet earth),’” says Henry M. Bartlett, executive director of the Committee of Methadone Program Administrators of New York State (COMPA). “It has nothing to do with the evidence.” COMPA would like to prevent the proposed legislation from being enacted, he says. “But if it is, we will challenge it.”

And a challenge would succeed, because the law would be illegal, according to the Legal Action Center. “This bill flatly violates the Americans with Disabilities Act (ADA), which prohibits discrimination based on disability,” says Catherine O’Neill, senior vice president with the Legal Action Center. The bill also violates antidiscrimination provisions of New York State’s human rights law, she says, noting that addiction is classified as a disability under federal and state law.

Counsel for the Senate would not have drafted a bill that they thought would be illegal, says Mr. Shafran, told of the Legal Action Center’s opinion. “That said, the bill is in the early stages, so significant changes are likely,” he told *AT Forum*.

The state Office for Alcoholism and Substance Abuse Services (OASAS) told *AT Forum* it is reviewing the bills, but noted that it already includes

input from local government and from the community before approving an application for an operating certificate. OASAS suggested that programs already sited were previously approved by local communities. “We expect our providers to have engaged in community outreach prior to submitting an application,” says OASAS spokeswoman Jennifer Farrell. “All these factors are considered before OASAS sites a program.”

Mr. Shafran said he didn’t know how many OTPs are in Senator Sampson’s district. Asked for evidence that OTPs were “dangerous” and linked to loitering and vandalism, he says the documentation for that is mostly in the Senator’s district office in Brooklyn (which refers all press calls to Mr. Shafran), and that it usually comes via “complaints from constituents.”

Patients know that loitering is against OTP rules, and programs take these issues seriously, says COMPA’s Mr. Bartlett. “We don’t have any objection to patients’ shopping in the neighborhood—that isn’t loitering,” he says. “But when you have no legitimate business to be somewhere, you shouldn’t be there.”

State and federal regulators require OTPs to minimize negative impact in their communities, and if they fail to do so they risk the loss of funding or licensure.

Perhaps even more important than the legal argument is the human one. Patients in medication-assisted treatment deserve to be rewarded for their hard-won recovery, not stigmatized and marginalized, notes Mr. Bartlett. More than 38,000 New York residents receive treatment in OTPs, most of them in the communities where they live.

The bills (A5529 and S00094) were referred to the Assembly Committee on Alcoholism and Drug Abuse in January, and to the Senate Committee for Mental Health and Hygiene in March, where they were expected to languish.

But, just in case, COMPA is urging OTPs to contact all of the sponsors, to express their opposition to the bills. COMPA also urges contacting Assembly Speaker Sheldon Silver, Assemblywoman Amy Paulin (Chair, Assembly Committee on Alcoholism & Substance Abuse), Senator Malcom Smith (Temporary Senate President), and Senator Pedro Espada, Jr. (Majority Leader). Mailing addresses and contact information for Assembly Members can be found at <http://assembly.state.ny.us/mem/> and for Senate Members at <http://www.nysenate.gov/senators>.

**Sources:** For more on the bills, go to <http://open.nysenate.gov/legislation/api/mobile/bill/A5529> and <http://assembly.state.ny.us/leg/?bn=S00094>.

## NEW RESOURCE

### Special N-SSATS Report: 2008 Overview of OTPs in the U.S.

As a follow-up to the release of the 2008 National Survey of Substance Abuse Treatment Services (N-SSATS), the Substance Abuse and Mental Health Services Administration, Office of Applied Studies, has issued a short report on opioid treatment programs (OTPs). Published in late January, the report overviews OTP facility operation and location, payment options and funding, services offered, counseling and therapeutic approaches, and specific pharmacotherapies used. The 6-page report can be accessed at: <http://oas.samhsa.gov/2k10/222/222USOTP2k10Web.pdf>.

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## Kentucky Study Shows Positive Outcomes for MAT Patients



Results from a recent Kentucky Opiate Replacement Treatment Outcome Study (KORTOS) show that medication-assisted treatment (MAT) for opioid addiction resulted in reduced use of all substances of abuse (excluding tobacco), decreased legal involvement, improved educational status, stable employment status, and increased use of available recovery support.

The goal of the ongoing, state-sponsored KORTOS project is to examine the social functioning of patients participating in MAT. The project is designed and managed by the University of Kentucky Center on Drug and Alcohol Research (UKCDAR), through a contract with the Division of Behavioral Health and the Kentucky Narcotic Treatment Authority. Data were collected in licensed opioid treatment programs. They are based on 191 patients at 12 months prior to intake for MAT, and at follow-up six months after admission.

### Declines in All Substances of Abuse

MAT reduced the use of cocaine, marijuana, alcohol, and, most notably, prescription opioid abuse. There was an 85 percent reduction in the use of more than one substance per day, excluding tobacco.

The study, released in January 2010, also found that MAT was associated with a 78 percent reduction in arrests, a 47 percent reduction in time spent in jail, and a 75 percent increase in the use of recovery support groups.

The KORTOS outcomes brief report can be accessed at: [http://cdar.uky.edu/KORTOS/Downloads/KORTOS\\_brief\\_outcomes\\_report\\_Jan\\_2010\\_FINAL.pdf](http://cdar.uky.edu/KORTOS/Downloads/KORTOS_brief_outcomes_report_Jan_2010_FINAL.pdf).

Substance Abuse	At 12 Months Prior to Intake (%)	At 6-Month Follow-up (%)	Decrease at Follow-up (%)
Alcohol	58.6	18.3	69
Cocaine	36.1	7.9	78
Heroin	18.3	5.2	72
Marijuana	49.7	14.1	72
Methadone (illicit)	57.6	8.4	85
Prescription opioids	95.8	27.2	72
Stimulants	19.4	3.7	81
Used more than one substance per day (excluding tobacco)	79.1	12.0	85

Source: University of Kentucky CDAR on behalf of the Kentucky Division of Behavioral Health-January 21, 2010.