Other Substances of Abuse

One example of a conflict is the patient who continues to use other drugs, or alcohol, or both. The patient may claim to have alcohol or drug use under control. Because denial is a hallmark of addiction, the treatment program should choose beneficence over autonomy, and engage the patient in comprehensive treatment designed to avoid other drugs.

Some OTP clinicians are uncomfortable with the disease model, and expect immediate, total abstinence once patients are in MAT. From TIP 43: “When OTPs refuse to recognize that immediate abstinence is unrealistic and punish patients for the continuing but reduced presence of symptoms, they are not defining addiction as a disease. The long-term goal is always reducing or eliminating the use of illicit opioids and other illicit drugs and the problematic use of prescription drugs; but, in the short run, patients should be supported as they reduce their substance use.”

[continued on page 6]
I’ve been in methadone maintenance (MM) treatment for almost two years, and I’m making good progress in putting my life back together. I’m wondering if I should taper off methadone, and how long it would take if I do.

It’s not essential for you to stop taking methadone. Many patients continue to take it for a lifetime. But if you decide to taper, generally the longer you stay in recovery in your opioid treatment program (OTP) before tapering, the greater your chances for success.

Leaving MM too early, or for the wrong reasons, can lead to a relapse. Almost all patients who choose to leave MM and do not taper or take part in ongoing recovery services eventually return to illicit drug use or alcohol abuse.

It’s important to remember that opioid addiction is a chronic, relapsing brain disease. Methadone works by blocking the opioid receptors, interfering with the effects of opioids in the body. Some methadone-maintained patients regain normal brain function in a few years. Others need to take methadone for longer periods; some, for a lifetime.

Predictors of Success in Tapering

Some factors that contribute to a patient’s success in tapering include strong motivation, stable financial and housing resources, good support systems (especially family and friends), long-term abstinence from illicit drugs and alcohol abuse, and continuing access to medical and mental health care. Also important are how long the patient has been addicted, whether the patient has joined a peer group that does not use drugs, and whether the patient has tried previously to discontinue methadone.

A patient’s age, race, sex, and educational level are not related to successful tapering.

Returning to Methadone Maintenance

Patients who taper can decide to return to MM at any time, for any reason. Those who complete tapering, and no longer take methadone, can help avoid relapse by periodically visiting their clinic physician or primary counselor, or becoming involved in peer recovery support services.

Lowering the Methadone Dose During Tapering

If you’re stabilized in maintenance treatment, a safe and comfortable way to discontinue methadone is Medically Supervised Withdrawal, or MSW. This involves reducing the daily methadone dosage in small amounts, over time.

The brain needs to adjust gradually to each dose reduction, and some patients need more time than others between decreases. The methadone tapering process has no time limits, for each patient responds differently. Tapering may continue for many months, even a year or more. Some patients may have difficulty tapering, and may either stop the taper, raise the methadone dose, or return to an adequate dosage level for an indefinite time.

Should I Taper Off Methadone?

Q: I’ve been in methadone maintenance (MM) treatment for almost two years, and I’m making good progress in putting my life back together. I’m wondering if I should taper off methadone, and how long it would take if I do.

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Deciding Whether to Taper
Whether or not you taper is up to you. If you’re strongly motivated, and decide to go ahead, your OTP physician and primary counselor will support you and provide input. They’ll help you keep a sense of control and responsibility over your treatment, including choosing the right tapering speed.

The methadone tapering process has no time limits, for each patient responds differently.

During MSW, regularly scheduled visits to the clinic physician and the counseling staff can help ensure that your medical and emotional needs are being met, making it more likely that your tapering will be successful. Also helpful is to join peer support groups that connect you with other recovering individuals.

The sidebar lists questions that can help you decide if MSW is a good choice for you. The more questions you answer with a “yes,” the more likely MSW is right for you. Each “no” indicates an area that you can work on if you want to increase your chances of successfully tapering.

Sources: See www.ATForum.com

Should I Taper Off Methadone? (continued)

Your Winter 2011 article notes that the Department of Defense TRICARE insurance plan excludes payment for maintenance treatment of opioid dependence. In my opinion, similar problems exist in the insurance plan of the Department of Veterans Affairs (VA) and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), and even the VA health care facilities do not provide the “gold standard” of care for opioid dependence.

From a 2009 VA statement entitled “Substance Use Disorders” (http://www.queri.research.va.gov/sud/wwd/oat/): “Medication-assisted recovery for opioid dependence has a well-established evidence base as a cost-effective approach to improving treatment retention and clinical outcome. It is an identified priority in the MH [mental health] Strategic Plan. In FY07, [Veterans Health Affairs] served over 27,000 patients diagnosed with opioid dependence, but fewer than 1 in 5 received on-going methadone or buprenorphine.” Nevertheless, the statement goes on to say that 1,609 veterans—less than six percent—received prescriptions for buprenorphine from the third quarter of fiscal year 2006 to the second quarter of fiscal year 2007. No information is given as to the average duration of opioid treatment [either methadone or buprenorphine]; individual patients could have received treatment for an entire year or for only a few days.

The VA publication cited above goes on to state, “Unfortunately, only 40 VA opioid agonist therapy programs exist” in the VA system. According to a 2007 report prepared by the Congressional Budget Office, the VA Health System comprises 153 medical centers and 882 ambulatory care and community-based outpatient clinics (www.cbo.gov/ftpdocs/88xx/doc8892/12-21-VA_Healthcare.pdf). In other words, opioid dependency treatment programs are provided in less than four percent of all VA health care facilities.

Of course, the 27,000 figure reflects only the veterans who receive care in the system and have a recorded diagnosis of opioid dependence; 80 percent of veterans do not use the VA for their health care, according to the Veterans Health Council (http://www.veteranshealth.org/about.html). And for those who choose to receive their care outside the VA system, the otherwise comprehensive health insurance available to them (CHAMPVA) excludes coverage for maintenance with either methadone or buprenorphine.

Robert G. Newman, MD, MPH
The Baron Edmond de Rothschild Chemical Dependency Institute

*Reader responses are not necessarily the opinions of AT Forum.
Investigators recently interviewed three groups of participants who were misusing prescription opioids and sedatives, including benzo-azepines: patients in methadone maintenance treatment (MM), street-based illicit drug users, and patients in residential drug-treatment programs, to determine their motives for misuse. To be eligible, individuals had to report abusing prescription drugs at least five times within the previous 90 days (taking them without a legitimate prescription, or taking them in ways not prescribed by a physician). The study’s nearly 700 participants were drawn from almost 2,000 prescription drug abusers enrolled in the South Florida Health Survey, funded by the National Institute on Drug Abuse (NIDA).

**Findings**

Each study participant averaged three motives, the most common: to get high, to sleep, and to help relieve anxiety or stress. Other motives included relieving pain, moderating other drugs’ effects, and substituting for other drugs. Less common were withdrawal avoidance, sexual enhancement, and social pressure. Compared to other participants, a higher percentage of MM prescription drug abusers reported “pain relief” and “relieving anxiety or stress” as motives, while a lower percentage mentioned “to moderate the effects of other drugs.”

**Getting high** — Participants who said their primary reason was “having fun” or “getting high” tended to smoke, snort, or shoot the drugs—to get a quicker, more intense, or longer-lasting high. But over time, “avoiding drug withdrawal symptoms” usually replaced “getting high,” as recreational use transitioned into apparent dependence and addiction.

**Coping with anxiety and stress** — Participants said anxiety and stress were due to childhood abuse, job loss, overall lack of satisfaction with life, and problems with relationships, child custody, or housing. Ironically, the drug misuse that at first helped them cope, later created new problems, such as job loss and child custody issues.

**Moderating the effects of other drugs** — Almost everyone in the study misused a variety of prescription drugs, street drugs, and alcohol. Nearly half said they used prescription drugs to accentuate or supplement the effects of other drugs, or to help them “come down.”

**Avoiding withdrawal symptoms** — Those trying to avoid physical symptoms of withdrawal from prescription opioids or sedatives, including benzo-azepines, tended to be long-term heavy users. They described themselves as “addicts” who rarely felt any pleasure from the drugs, but instead used them to “feel normal.”

**Suggestions for Opioid Treatment Programs**

Motivational interviewing has become an increasingly important tool in addiction counseling, largely because it helps patients understand and resolve competing motivations, thus leading to a positive change in behavior. Yet less than half (43 percent) of OTPs use this approach on a regular basis. This study gives counselors insights into specific motives that can compromise treatment effectiveness. Focusing on these motives will help counselors develop specific treatment plans, so they can provide better outcomes for their patients.

**Study Limitations**

Because of the study design, recall bias and interview bias are possible. The validity of the estimates is unknown.


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**Subgroups Listing Different Motivations:**

- **Younger participants:** “to get high”
- **Older ones:** “pain relief”
- **Men:** to substitute for other drugs, or in response to social pressure
- **Black/African American:** to moderate the effects of other drugs
- **White:** for pain relief, or to relieve anxiety or stress
- **Hispanic/Latino:** to relieve anxiety or stress, or to get high

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**Patients Given Rx Opioids for Chronic Pain Need Closer Oversight: Study**

High-risk patients taking Rx opioids for chronic non-cancer pain need opioid risk-reduction strategies and closer oversight, according to a study published in the February 24 online edition of the Journal of General Internal Medicine. Even patients at higher risk of misuse with a history of drug use disorder did not receive urine drug testing frequently enough, and often had early refills, according to the study.

“Our study highlights a missed opportunity for identifying and reducing misuse of prescribed opioids in primary care settings,” says lead author Joanna Starrels, MD, MS, assistant professor of medicine at Albert Einstein College of Medicine. “The finding that physicians did not increase precautions for patients at highest risk for opioid misuse should be a call for a standardized approach to monitoring.”

The study examined records of more than 1,600 primary care patients receiving opioids for chronic, non-cancer pain during a two-year period. Only eight percent of the patients underwent urine testing, and only half the patients were seen in the office regularly.

“We were disturbed to find that patients with a drug use disorder were seen less frequently in the office and were prescribed more early refills than patients without these disorders,” says Dr. Starrels.

Benadriazepine use and abuse by patients is one of the biggest challenges facing opioid treatment programs (OTPs), says Jan Kauffman, RN, MPH, vice president of addiction treatment services for North Charles Institute for the Addictions, Somerville, Massachusetts. Ms. Kauffman is also a consultant at Cambridge Health Alliance, Boston, Massachusetts, and assistant professor of psychiatry at Harvard Medical School. “This is a critical issue for methadone safety, with the potential for drug interaction and overdoses,” she told AT Forum.

**Ideally, when there is legitimate medical need, the OTP physician should prescribe both a benzodiazepine and methadone.**

In order for clinicians to better understand the use of benzdiazepines and other psychiatric medications, the Center for Substance Abuse Treatment (CSAT) at the Substance Abuse and Mental Health Services Administration (SAMHSA) has convened the Pharmacotherapy Expert Consensus Panel to consider best practices for substance abuse treatment programs, especially in OTPs. Ms. Kauffman serves on this panel.

**Importance of Coordinating Care**

Ideally, when there is legitimate medical need, the OTP should treat co-occurring psychiatric as well as opioid dependence disorders. This allows for coordination of care and compliance oversight. This model however, has staffing and reimbursement challenges for the OTP. If it is not feasible, the outside prescribing physician and the OTP physician must work cooperatively with OTP medical staff, with the patient’s informed consent, to ensure integrated, coordinated care. Ms. Kauffman stressed to AT Forum that greater care is needed during the OTP induction phase to ensure that the patient is taking each medication as prescribed and is tolerating both well. Drug testing to ensure that the patient is not supplementing the prescribed benzodiazepines with street purchases is critical.

Because of the potential for respiratory depression when a patient is taking both methadone and a benzodiazepine, it’s essential that the program educate the patient, says H. Westley Clark, MD, JD, director of CSAT/SAMHSA. “Neither the program, nor the patient, nor the prescribing physician, wants an overdose.”

**Treatment Versus Termination**

If a patient tests positive for benzodiazepines, the OTP “has to carefully consider the situation. Where did the benzodiazepine come from? If it’s illicit, that could be a problem,” says Dr. Clark. Ms. Kauffman adds, “Even with prescribed benzodiazepines, there’s a possibility for abuse.”

Dr. Clark, who is an attorney, questions whether it is in the interests of either the patient or the program to terminate methadone treatment just because of continued benzodiazepine use. “First of all, is this medically defensible? Secondly, we’re trying to keep this a low litigious environment. If you come up with rules, you subject yourself to litigation.”

Finally, Dr. Clark noted that abrupt discontinuation of benzodiazepine use is dangerous. “If you discover that a new patient is using benzodiazepines, you need to think about how to best engage that patient. Maybe the patient needs a driver, or a bus, or a cab. But that’s better than saying, ‘I will not treat you,’ and have the patient go to the street to get more benzodiazepines and heroin, and then get behind the wheel of a car.”

“We aggressively try to develop a treatment plan for these patients,” says Ms. Kauffman, adding that “abuse of benzodiazepines is a significant problem in methadone treatment.” She makes every effort to keep patients in treatment, sending them for an inpatient benzodiazepine taper while they are maintained on methadone. After the taper, the patient returns to the OTP. “Sometimes it’s hard to get people to comply,” she concedes.

Dr. Clark expects the panel’s guidelines to appear some time before the end of the year. AT Forum will publish updates on the guidelines’ progress.

**METHADONE RECOVERY FIELD LOSES BRAVE, PIONEERING ADVOCATE**

Lisa Mojer-Torres, JD, passionate advocate for medication-assisted treatment and recovery, and recent co-author with William L. White, MA, of a ground-breaking monograph, *Recovery Oriented Methadone Maintenance (ROMM)*, died April 4 of ovarian cancer. The 54-year-old civil rights attorney was a board member of the National Alliance for Methadone Advocates, founding member and first board chair of Faces and Voices of Recovery, and recipient of many awards, including the 2010 Richard Lane/Robert Holden Patient Advocacy Award from the American Association for the Treatment of Opioid Dependence. She was also the recovery advocate for the New Jersey Division of Addiction Services.

“Lisa was a true pioneer for those seeking recovery, especially those in medication-assisted recovery,” said Michael T. Flaherty, PhD, executive director of the Institute for Research, Education and Training in Addictions (IRETA). “While many fled from advocating for those needing medications to achieve and sustain their personal recovery, Lisa told her story. She brought reality to recovery for those individuals and their families.”

To hear Lisa’s message, go to www.ireta.org, click on Addiction Recovery Symposium (lower left column, under Featured Links), go to Video of Presentations, click on Symposium Presentations — Videos, Aligning Special Population Needs with Recovery Oriented Systems of Care, and select Lisa’s name.

Ron Jackson, MSW, executive director of Evergreen Treatment Services in Seattle, Washington, draws the line at nine positive drug tests in any 12-month period. After the ninth positive test, the patient is required to go to a treatment-team meeting. “We may ask what the patient needs to do differently, and what we need to do differently to help the patient stay in treatment,” says Mr. Jackson. In some cases, these patients may have to be discharged.

Mr. Jackson also thinks it is not ethical to continue giving methadone to a patient who has clear evidence of unremitting benzodiazepine abuse or impairment. “In my opinion, that would ignore the potential harm to the patient.”

Involuntary Discharge
Terminating treatment—discharging a patient against the patient’s will—is probably the most blatant breach of all four ethical principles—autonomy, beneficence, nonmalfeasance, and justice. And yet, OTPs must balance the interests of patients facing discharge with the interests of their compliant patients.

Threatening violence, coming to treatment with a weapon, or dealing drugs at an OTP are clear safety threats to other patients and to staff. These are grounds for involuntary discharge, according to TIP 43.

Involuntary discharge for non-payment is not as simple. A patient who doesn’t have the money for treatment, but is doing well, will likely relapse if discharged. OTPs could mitigate harm by devising payment schedules, or facilitating a transfer to a lower-cost program.

Take-homes
Patients almost always want to reduce visits to the OTP, but the authority lies in the OTP to grant or withdraw take-home privileges. Dispensing take-home medication irresponsibly can cause grave harm to patients and their families, and threaten the very existence of the clinic.

Mark Parrino, MPA, president of the American Association for the Treatment of Opioid Dependence (AATOD), was a clinic administrator for 15 years. “Many times a concerned patient would ask me, ‘Why were my take-homes withdrawn?’” he recalls. “Most of the time it was a sound decision, usually based on drug abuse or lack of compliance with a published program standard.”

But at times there was an “arbitrary nature to the decision-making,” says Mr. Parrino. This is where good clinical judgment and good program management are very important.

Clinicians can be ill-informed and lack compassion, and will use take-home medication “as a sword of Damocles to drive patient compliance,” he says. But there are also times when staff are genuinely frustrated, and don’t know what else to do.

Federal rules state that only a physician is responsible for determining dose and schedule, says Walter Ginter, CMA, founder and director of the Medication-Assisted Recovery Services (MARS) Project, and director of training and recovery services with the National Alliance for Medication-Assisted Recovery (NAMA). But many physicians rely on the treatment team, particularly the counselor. This gives the counselor considerable power, to the point that some patients won’t share anything that might damage take-home privileges. Unfortunately, giving counselors this power reduces the likelihood that a therapeutic relationship will develop.

Due Process
The decision to discharge a patient involuntarily or adjust take-home privileges might require that a treatment provider or administrator resolve disputes or differences between a staff member and a patient. It is important that an OTP provide a forum for a fair hearing, including a review of the facts and proposed sanctions. Some states require additional due-process procedures.

Paradoxically, the counselor is the first person the patient with a complaint must turn to, says Mr. Ginter. The official chain is the counselor, the clinic supervisor, and, in some clinics, an appeals committee, where patients can appeal decisions made by the clinic administrator. The next step is usually the State Opioid Treatment Authority (SOTA).

Suggestions for OTPs
OTP with “noncompliant” patients need to find thoughtful ways to motivate, engage, and develop goals with them, says Mr. Parrino. Patients shouldn’t be punished for not responding to treatment. And providers must first understand and then be sensitive to the power relationship that ultimately exists—unspoken in some places, wielded in others—to withhold medication or treatment. “It’s not about ethics, it’s about patients getting good care,” Mr. Parrino says. “It’s always been about a standard of care.” And that standard is embodied in TIP 43.

To reach Mr. Ginter at NAMA, call 212-595-6262, or e-mail namavp@yahoo.com.

Footnote: The “Ethical Considerations in MAT” part of TIP 43 is an appendix, because it was not as evidence-based as the main body of the TIP. Mr. Parrino says. However, the passion of the people involved in putting the document together—including Mr. Jackson—shows how significant the principles are to OTPs.

The TIP 43 appendix on ethical considerations is available at: http://www.ncbi.nlm.nih.gov/books/NBK25990/

OTP UsesWebsite to Communicate With Patients, Staff, and the Community

Brandywine’s website includes staff profiles and services offered—anger management classes, employment-skills sessions, and HIV testing—along with pamphlets on overdose prevention and methadone myths and facts.

When someone is looking for treatment for opioid addiction, the Internet may be the first place they turn for information. Brandywine Counseling and Community Services has a good website that not only makes potential patients aware of the services they offer, but showcases patients in medication-assisted treatment (MAT) who have been successful.

Many patients and family members use the Brandywine website as their first contact with the Wilmington, Delaware-based non-profit group of two opioid treatment programs (OTPs). “We’ve never had to advertise, and we get a constant inflow of new patients,” says James Harrison, site director of the Lancaster Avenue program. “Our website has given people the opportunity to e-mail us with questions they may have about MAT.”

The entire intake process can be initiated by that first e-mail. Many people feel more comfortable sending an e-mail describing their situation than talking with someone on the phone or in person, says Matt Friedman, who is the program’s executive assistant and resident information technology (IT) expert.

When Mr. Friedman joined Brandywine in 2002, the program already had a website. “I rebuilt it from scratch,” he says. Mr. Friedman also writes a website blog, which automatically imports to the program’s Facebook and Twitter sites.

Mr. Friedman notes that Facebook can present some problems for patients in MAT because they are concerned about their privacy. “We’ve had the page for four years, and there’s a lot more we could be doing with it,” he says. “The challenge for us is that patients don’t really want to join a Facebook page, because of confidentiality.” Of course anyone can post to a Facebook page, or follow a Twitter feed, without disclosing personal information.

Building Patient and Community Relations

Their site also promotes Brandywine to the public, and is included on all brochures and business cards. “We just did new signs for the organization, and every sign, every card with our logo, includes our Web address,” says Lynn M. Fahey, PhD, executive director of Brandywine.

In general, websites bring OTPs out of hiding, via the Internet. For too many years OTPs have not advertised who they are, but instead have been housed in nondescript buildings with no signage, notes Dr. Fahey. “Now we want to create an atmosphere that we are a place where people want to come, as opposed to a place where they need to come because they need their medicine.” Brandywine has spent a lot of effort on the “aesthetics” of the facilities, she says. “We want to create a doctor-type environment.”

This atmosphere is conveyed on the website, which is good for public relations and patient relations as well.

The site has also helped attract new hires, volunteers, and donors. Job applicants look at the website and like the variety of programs offered, says Mr. Harrison. “It’s very important for content to be culturally sensitive. We treat a broad range of patients, and many of our contracts are state-funded.”

A website should reflect what a program does—and this is especially important if you are seeking grants. “If you have funders that are looking for prevention, and your website looks as if all you do is treatment, it will turn them off,” says Dr. Fahey.

Publisher’s Note

In addition to Brandywine’s website content, described above, there is valuable information on staff profiles, hours of operation, and services offered, including anger-management classes, employment-skills sessions, and HIV testing. Brandywine provides news announcements and photos on events (e.g. Client Appreciation Day, Giving Tree toy-giveaway, and a softball tournament), patient-satisfaction surveys, and notices on openings delayed due to inclement weather. They also offer online publications, including patient handbooks, pamphlets on overdose prevention, and methadone myths and facts.

Suggestions for OTPs

Consider the value of developing a website to improve communications with patients, staff, and the local community. Depending upon the funds available, you could start with information on your OTP location (include a map), hours of operation, contact information (include e-mail), and staff members, and include some basic information on opioid addiction and MAT.

You may be surprised how affordable it is to start developing a website that can be expanded over time. When your site is up and running, send a press release to your local media to let them know where to find you on the Web.

To visit the Brandywine website, go to http://www.brandywinecrafteling.org/index.html. The website includes links to their Facebook and Twitter pages.

Pennsylvania Legislators Continue to Take Aim at OTPS

Opioid treatment programs (OTPs) in Pennsylvania are targeted for stricter regulation by some state legislators. Senate Bill 955, would require OTPs to be open seven days a week, to limit take-homes to patients who had been in treatment more than six months, and to require treatment plans aimed at abstinence. To access the bill, introduced April 8, go to: http://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2011&sind=0&body=S&type=B&bn=0955.

Another Pennsylvania bill, introduced in March, would restrict OTP patients who participate in the Medical Assistance Transportation Program to four weeks of transportation—including both mileage reimbursement and para-transit services—to the clinic closest to their residence. Senate Bill 638 can be accessed at: http://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2011&sind=0&body=S&type=B&bn=0638.
Bill to Impose Restrictions on Methadone Proposed in Congress

On March 8 Sen. Jay Rockefeller (D-W.Va.) proposed a bill that would, if passed and signed into law, impose new restrictions on opioid treatment programs (OTPs). Although the bill is called the Prescription Drug Abuse Prevention and Treatment Act of 2011 (S. 507), and includes other opioids and pain management, it singles out methadone and OTPs for the strongest measures.

Two years ago, Sen. Rockefeller proposed similar legislation, called the Methadone Treatment and Prevention Act (S. 754). The reasoning behind this year’s bill is similar: an increase in overdose deaths due to prescription opioids.

Sen. Rockefeller’s proposal—there is so far no other sponsor—would provide for educating physicians who prescribe methadone and other opioids in OTPs, as well as those who prescribe these medications for pain. One provision would require anyone who prescribes opioids to complete an education program. Another sets particularly high standards for OTP physicians—a 16-hour training course, to be repeated every three years.

Patients would receive education in avoiding diversion and misuse; most teens who abuse opioids get them from friends or relatives. The use of methadone as a painkiller has increased, and many pain patients are unaware of or don’t understand methadone’s long half-life—the property that makes methadone long-acting, and therefore valuable as a medication for treating both opioid addiction and chronic pain.

S. 507 would also:

- Create a Controlled Substances Clinical Standards Commission to establish dosing guidelines for methadone, whether used in OTPs or for pain
- Appropriate $25 million for the National All Schedules Prescription Electronic Reporting Act (NASPER), a prescription-drug monitoring program that would help prevent patients from doctor-shopping across state lines
- Require OTPs to make alternative arrangements for dispensing methadone on Sundays and holidays, when many are closed—something OTPs regard as particularly problematic

For a copy of the bill and updates on its progress through Congress, go to http://thomas.loc.gov/cgi-bin/query/z?c112:S.507:IS:

A Controlled Substances Clinical Standards Commission would be created to establish dosing guidelines for methadone, whether used in OTPs or for pain.