ADDICTION TREATMENT

Forum

THE QUARTERLY NEWSLETTER OF ADDICTION TREATMENT FOR CLINICAL HEALTH CARE PROFESSIONALS

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MMT & Beyond

Shifting Paradigms & Slippery Slopes

Cautious Optimism

"Heroin's New Fix," hyped the headline of a story last May 31st in *USA Today*,[1] the highest daily circulation newspaper in the country. The lead paragraph proclaimed, "Scientists are ready to usher in a generation of anti-addiction drugs that could significantly improve the prognosis for the nation's 1 million heroin addicts." And, NIDA director Alan Leshner declared, "This could be the biggest advance in the last 10 years. We're very optimistic."

Although such articles promoting the benefits of addiction treatment make positive contributions to public perception, certain aspects of this story also might temper optimism with caution.

The *USA Today* article by Donna Leinwand accurately described three emerging paradigm shifts in the field of opioid-addiction treatment:

- Accreditation of methadone maintenance treatment (MMT) programs resulting in less regulation, more reliance on clinical judgment, and greater accountability for outcomes;
- A new focus on office-based opioid treatment (OBOT, or medical maintenance), which officials hope will better serve a new generation of addicts;
- New medications – buprenorphine, a combination buprenorphine/naloxone, and a long-lasting naltrexone formulation – are being advocated as "superior, less-addictive alternatives to methadone" and welcome additions to the clinician's toolbox.

The new treatment approaches and new medications may prove effective.

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Clinic Notes

MMT Accreditation: Hard Work Ahead

Revolutionary Changes

In July 1999, a document was entered into the Federal Register (Vol. 64, No. 140, pp 39810-39857) that could bring revolutionary changes to methadone maintenance treatment (MMT) programs in the US. With the ominously lengthy title, "Narcotic Drugs in Maintenance and Detoxification Treatment of Narcotic Dependence; Repeal of Current Regulations and Proposal to Adopt New Regulations," the proposed rule includes the repeal of existing regulations enforced by the Food and Drug Administration (FDA), the creation of a new regulatory system based on an accreditation model, and a transfer of administration and regulatory oversight to the Substance Abuse and Mental Health Services Administration (SAMHSA).

Team Approach

The proposed rule reflected recommendations from a 1995 report by the Institute of Medicine, as well as from other entities, to improve MMT programs by allowing for increased clinical judgment in treatment, with a focus on patient care. Although that concept was warmly received by the methadone treatment community, there was some trepidation as to what the accreditation process would entail. Perhaps, rightly so.

According to the Federal Register, there are about 900 opioid treatment programs (OTPs) in the US (also referred to as NTPs or narcotic treatment programs, or MMT programs in this publication since methadone is still the primary medication employed). As part of an orderly

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Events to Note

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

OCTOBER 2000

National Alliance of Methadone Advocates Consumer Group; 3rd National Harm Reduction Conf.
October 21-25, 2000
Miami, FL
Contact Suzie Ko: 212-213-6376 x31
suzie@harmreduction.org

ASAM Review Course in Addn. Med.
October 26-28, 2000
Chicago, IL
Contact: 301-656-3920
email@asam.org

NOVEMBER 2000

Social Work 2000 Natl. Conf.
November 1-4, 2000
Baltimore, MD
Contact Jessica Berry: 703-739-4480
jberry@teamprecision.com

17th Ann. Gulf Coast Conf. on Drugs & Alcohol
November 2-3, 2000
Mobile, AL
Contact: B. McCormick: 334-431-6411
bamccormickUSA@aol.com

Addiction 2000 Millennium
November 15-17, 2000
Toronto, ONT
Contact: 905-335-7993
Marianne.mms@sympatico.ca

13th Ann. U.S. Psychiatric & Mental Health Congress
November 16-19, 2000
San Diego, CA
See: www.mhsource.com/congress/index. html

DECEMBER 2000

Med. Review Officer Training; ASAM
December 1-3, 2000
Contact: 301-656-3920
email@asam.org

AAAP 11th Annual Mtg. (Amer. Acad. Addn. Psychiatry)
December 7-10, 2000
Phoenix, AZ
Contact: 913-262-6161
info@aaap.org

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Straight Talk... from the Editor

Patient? Client? Who are we talking about?

Scottish philosopher Thomas Reid wrote, "There is no greater impediment to the advancement of knowledge than the ambiguity of words."

That reminds us of the American Methadone Treatment Association conference last spring. We heard physicians and medical researchers speaking of persons in addiction recovery programs as "patients," followed by psychologists, counselors, or others referring to those very same people as "clients."

Should this *patient-client* ambiguity be of concern? Or, should we be resigned to the advice of an old Yiddish proverb, "A wise man hears one word and understands two?"

Terms of Endearment

Many would argue that *client* is intended as respectful and less stigmatizing. However, patient-client disparities also may be role-related with attitudinal undertones.

Doctors and nurses – medical people – treat *patients*. Staff with non-medical degrees may feel it more appropriate to call their charges clients, to distinguish that they are not practicing medicine. Still, use of *client* would appear to portray drug addiction as a behavioral problem, rather than a medical condition for which medications like methadone are bona fide treatments. Are diabetics ever called "insulin clients"?

Bafflement in Print

Government agencies have followed an inconsistent approach in their publications. Whereas, the National Institute on Drug Abuse has encouraged use of "patient," the Center for Substance Abuse Treatment (CSAT) is apparently *client*-focused. For example, a 1999 CSAT Fact Sheet talks about how the agency's success "is reflected by *clients* at CSAT-supported treatment facilities." A CSAT publication on "Addiction Counseling Competencies" discusses treating *clients* in clinical settings.

One also can open almost any journal in the field of addiction medicine and find studies by physicians who treated *patients* and investigations by psychologists or sociologists who examined *clients*. Yet, all of the populations studied are persons with substance dependency and in recovery programs.

Vexing Concerns

A 1994 policy statement from the National Alliance of Methadone Advocates (NAMA) raised a number of red flags against the use of "client." A most vexing question was whether health insurers, in their quest to control costs, would be as willing to pay for *services to clients* as opposed to *patient care*. At the very least, they might claim that clinic offerings denoted as "client services" are outside the purview of medical reimbursement, even though such support might be essential for recovery.

Furthermore, would legislators be more amenable to approving funding for programs treating patients or benefitting clients?

Barry McCaffrey, head of the Office of National Drug Control Policy, has stressed that "words count" as they carry meaning, create expectations, and "turn people on or off when it comes to addiction treatment." Which term – *patient or client* – creates the most favorable expectations? Maybe they should all just be vaguely called "people in recovery"?

Survey – Patient or Client?

As usual, we want to know what our readers think. Please respond to the following questions:

Should persons in addiction treatment programs be called …patients ❒…or, clients ❒? (check one)

Are you responding as …a patient ❒ …a non-medical staff member ❒ …or, a medical staff member ❒? (check only one.)

There are several ways to respond: **A.** Provide your answers on the postage-free feedback card in this issue; **B.** Write or fax us [see info below]; or **C.** Visit our Web site to respond online. As always, your ***written comments*** are important to help us discuss the results in our next issue.

Stewart B. Leavitt, PhD, Editor
stew202@aol.com

Addiction Treatment Forum
1750 East Golf Rd., Suite 320
Schaumburg, IL 60173
FAX: 847-413-0526
Internet: http://www.atforum.com

A.T.F.

Part 5: Addiction and the Duress of Stress

"It's not I who become addicted, it is my body." – Jean Cocteau

The pioneering work of Hans Selye, MD, PhD, initiated in the 1930s, set the stage for present understandings of stress and its role in mental and physical illness.[1] Many common diseases are largely due to errors in the adaptive response to stress and, in this sense, drug addiction might also be viewed as an illness of maladaptation.

Stress is a double-edged sword. Cutting one way, there is distress – harmful or unpleasant experiences. Swinging the other way, there is *eustress* – euphoric or pleasurable events. Either way, stress spawns biological changes in the brain and body.[1]

Selye observed that stress is a response of the person to any demand; both distress and eustress produce virtually the same responses causing wear and tear. These changes also appear intimately connected to alcohol and other drug (AOD) abuse, dependency, and relapse. The nervous systems and hormonal mechanisms in chronic AOD users appear different, more sensitively tuned to the environmental and emotional stresses of life. Whether they become that way as a result of chronic substance abuse, are hypersensitive to begin with, or a bit of both, is an area of continued exploration.[2]

HPA Hormones

The body reacts to stress by secreting 2 types of chemical messengers: neurotransmitters in brain cells and hormones in the blood.

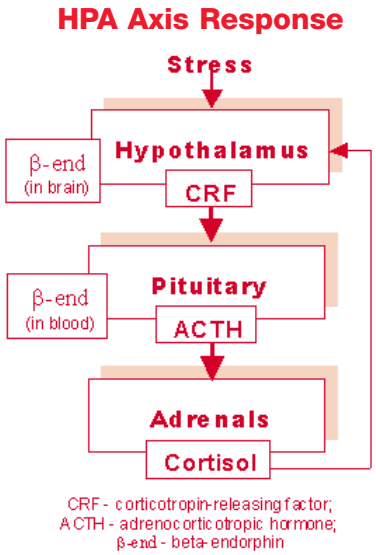
Stress hormones are normally released in small amounts throughout the day, but their levels increase dramatically when the person perceives an event as stressful. Then, hormones surge throughout the body energizing a variety of metabolic functions in preparation for action, like fighting or fleeing. Powerful emotions – aggression or anxiety – also are triggered to help drive the response.[3]

This stress-hormone response engages the hypothalamic-pituitary-adrenal (HPA) axis.[1,4] (See diagram.)

1. Hormonal response begins in the hypothalamus – a small gland at the base of the brain serving as a principal regulatory center for body functions – where *corticotropin-releasing factor* (CRF) is excreted into the bloodstream.[3,5]

2. CRF travels via blood vessels to the pituitary gland, a pea-sized structure attached by a short stalk below the hypothalamus gland. In the anterior (forward) portion of the pituitary, CRF stimulates the release of *adrenocorticotropic hormone* (ACTH).[3,5]

3. ACTH, in turn, travels in the bloodstream from the pituitary to the 2 adrenal glands, one perched atop each kidney. The outer portions of the adrenals (cortex) are stimulated by ACTH to release still other hormones, such as glucocorticoids. *Cortisol*, the most potent glucocorticoid in humans, travels through the body as an adaptation to external stress.[3-6] For example, cortisol increases blood sugar (glucose) and breaks down proteins and fats to help mobilize energy.[5] In the presence of severe stress, cortisol levels may increase up to 10-fold.[7]



Cortisol also provides a "negative feedback system." If the stressor is mild, when cortisol reaches the hypothalamus it inhibits further excess release of CRF, restoring ACTH and cortisol to normal levels. During intense stress, signals in the brain for more CRF release override inhibitory mechanisms and the stress reaction continues.[3]

Endogenous Opioids

The stress-adaptation cycle is complex, stimulated by chemicals in addition to CRF and ACTH, and inhibited by more than cortisol. Among the chemicals that help modulate stress are endogenous opioid peptides – small protein molecules that are neurotransmitters chemically similar to opioid drugs like heroin and morphine. The most potent of these is β-endorphin, produced in the hypothalamus and in the pituitary and affecting several brain centers (see diagram).[3-5]

The increased release of β-endorphin may induce a calming, relaxing effect that ameliorates reactions to stress.[5] Meanwhile, excess cortisol levels tend to antagonize (i.e., inhibit) β-endorphin and other endogenous opioids.[4] Thus, cortisol and β-endorphin function as part of an internal control cycle; first as a response to stress and then as a negative feedback mechanism helping moderate the stress response. However, chronic AOD administration disrupts this normal reaction to stress.

Anomalies of Addiction

For example, in addicts taking heroin, there is a *diminished* rise in ACTH levels in response to stress compared to normal nonaddicts. However, during periods of opioid abstinence, ACTH response *increases* twice as high as normal (see graph).[8]

The hormonal underreaction to stress in addicts actively taking opioids is due to inhibition of the stress system by the excess of opioid peptides in the brain. Those who are opioid-free have hypersensitive stress responses (overreaction) resulting from periods of cyclic drug withdrawal.[3,8]

The overreaction is sort of a rebound effect. Because most opioid effects last only 4 to 6 hours, withdrawal is experienced 3 or 4 times a day. The constant switching on and off of the stress response system leads to enduring hypersensitivity – stress chemicals surge at the slightest environmental or emotional provocation. Often, this triggers unpleasant sensations driving the person to take more opioid drugs[3] or to relapse even after prolonged periods of abstinence.[9]

In contrast to this, Kreek and others have noted that former opioid abusers maintained on methadone exhibit more normal levels of HPA hormones within the first several months of treatment. Although methadone acts at the

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"Brainstorm: Part 5"
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same brain sites as other opioids, it is much longer acting and, with proper dosing, the person will not be experiencing the stress of cyclic withdrawal that would otherwise sensitize the stress-response system.[3,8]

A Rat's Life

Laboratory studies using rats have greatly contributed to understanding the interactions between stress and AOD addiction, although there are physiologic differences in these animals as compared to humans.[2] To induce stress, the creatures have had their tails pinched and paws electric-shocked, they have been starved and restrained, and subjected to social isolation or aggression.

Ongoing rat research has demonstrated that stress may be intimately involved in drug craving and relapse. The 2 most important events in relapse after both long or brief drug-free periods are re-exposure to the drug itself, which activates pleasure pathways in the brain, and exposure to acute stress that stimulates HPA hormones.[10] Some research has found that relapse is of higher intensity when induced by stress that by priming infusions of drug.[6]

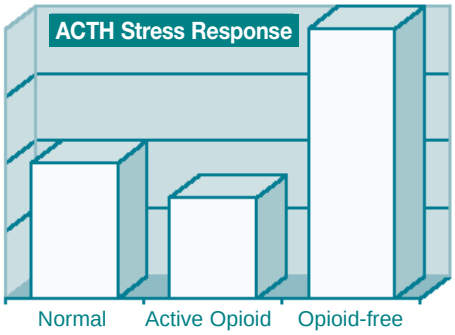
It was also found that repeated stress can induce long-lasting neurobiological changes creating a drug-prone state. Repeated stress appears to produce elevated levels of dopamine in the nucleus accumbens, a key component of the reward pathway in the brain.[6,11] Other experiments demonstrated that glucocorticoids, such as cortisol, may increase the activity of dopamine-producing neurons in the brain's reward pathway.[5]

Thus, stressful experiences stimulate the dopaminergic reward pathway. And, in the absence of stress, there is a withdrawal reaction that motivates drug seeking to maintain activity of the hormonal and neuronal systems providing reward effects.[5]

"Stressed-out" by Drugs

Stress control requires that the pituitary and adrenal glands produce and store a reserve of their hormones to rapidly respond to stimulation. Chronic AOD use may disrupt the usual pattern of adrenal hormone secretion, creating periods of deficiency or excess.[4]

Tennant and colleagues suggested that many clinical conditions in addicts – fatigue, depression, edema, diabetes, and obesity – are probably related to abnormal adrenal function. And, higher plasma cortisol levels found in opioid addicts during evening hours may produce withdrawal, anxiety, dysphoria, and insomnia.[4]



Via unabated hormonal stress responses, the HPA systems of addicts might become "stressed-out." Indeed, Tennant et al. commented on the lack of adrenal hormone reserves in the majority of heroin and cocaine addicts.[4] This might reinforce drug-seeking as an innate maladaptive attempt to restore hormonal balance and relieve stress.

Addiction Phenotype

Stress research has helped explain how the neurobiological status of an individual plays an important role influencing drug taking and vulnerability to dependency. Innate reactions to life experiences may induce an addiction-prone phenotype (i.e., personal characteristics determined by the interplay of environment and genetics).[5,6]

Potential genetic influences have been supported by experiments in rats, in which certain animals inherently show a higher level of dopamine release in response to drugs and a longer glucocorticoid secretion in response to stress. And, this higher dopaminergic activity seems to be dependent on glucocorticoid release. Thus, stress may both facilitate and perpetuate AOD dependency, and this also supports the idea that addiction is not merely an "iatrogenic disease" – i.e., induced simply by taking too much drug too often.[6]

Treatment Implications

Tennant and colleagues recommended a stress screening for all patients. Then, counseling efforts to help patients reduce stress might enhance neurobiological function and improve treatment outcomes, although this has not been specifically tested via research.[4]

Patients might also be placed on a nutritional regimen including a high-protein diet and vitamin supplements. This is to provide amino acids needed for the body to produce peptides found in HPA hormones. Although this makes intuitive sense, there is no scientific data yet to confirm benefits of the approach.[4]

Based upon available evidence, the HPA axis also could be a focus for new pharmacotherapies.[6] Scientists have explored a class of compounds called CRF-antagonists that block the action of corticotropin-releasing factor. Laboratory research in rats found that these agents block stress-induced relapse to drug seeking, and it is believed that these compounds may one day be useful in treating relapse to a variety of drugs, including heroin, cocaine, and nicotine.[3,12]

In sum, the stress response in chronic AOD users is a genuine neurobiological phenomenon different from that in normal persons. Addicts may react differently to stress to begin with and/or their stress-response systems may be altered as a result of substance abuse. Such altered responses may persist for quite some time, perhaps indefinitely, and stressful situations may trigger craving possibly leading to relapse in efforts to self-medicate either distress or eustress.

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However, there is still the question: Will the stigma, biases, and deficiencies that have unjustly haunted MMT programs for years be perpetuated and passed on to the newer therapies and a new generation of treatment providers?

MMT Bashing?

The *USA Today* article may portend slippery slopes ahead for MMT. It stated that, although MMT programs have been around since the 1970s, "[these] have had only moderate success." Furthermore, "Scientists and health officials say the new drugs could diminish methadone's role as well as that of clinics."

The author pointed to a study published in the *Journal of the American Medical Association* reporting that half of patients in a San Francisco MMT had used illicit opioid drugs at least monthly while in treatment. "Scientists called the finding 'not encouraging,'" Leinwand wrote.

The study in question, by Sees et al published March 8, 2000 in *JAMA*,[2] was designed to compare the outcomes of opioid addicts in MMT versus a psychosocially enriched 180-day methadone-assisted detoxification program (M180). It should be noted that the researchers' conclusions favored MMT as more useful than detox in reducing heroin use and HIV risk behaviors. However, this study appears to symbolize how many clinicians still see detoxification as the goal of treatment and seek to prove its benefits over long-term methadone.

Also, in many other ways, this study epitomizes the limitations of research investigating MMT over the years. Of particular concern, continued heroin abuse – 50% or greater monthly use rates in this study – is not an unusual finding in clinical research on methadone.

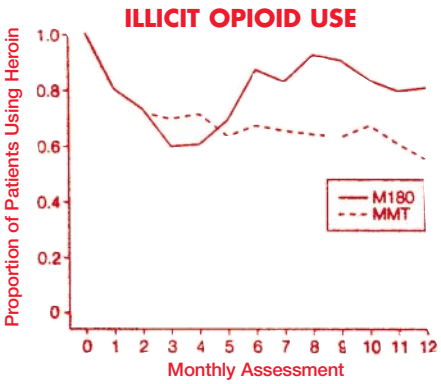
Why does this occur? Several aspects of the Sees et al. study seem noteworthy:

• A maximum 14 months of treatment was allowed; either continuous MMT or psychosocial aftercare following detox. Knowing treatment was time-limited, the patients' commitments to opioid abstinence must be questioned, and the authors noted that only 50% of the sample reported having a goal of total abstinence in the first place.

• There was an arbitrary dose ceiling of 100 mg/day, and both groups averaged roughly 85 mg/d. Is it possible that such doses were inadequate for half or more of the subjects, resulting in continued opioid abuse? Would methadone dose increases above 100 mg/d for the recalcitrant heroin abusers have resulted in greater abstinence rates?

• Considerable numbers of subjects had psychiatric diagnoses – depression, post-traumatic disorder, dysthymia, antisocial personality disorder – for which they were likely receiving psychoactive medications, and there was a high prevalence of alcohol and cocaine abuse. Such medications and drugs can interact with methadone metabolism, but this was not considered or discussed in the study.

• The attrition rate in the detox group was nearly twice that of the MMT group. Plus, heroin use escalated quickly in the detox (M180) group just as soon as methadone dose decreases began at 120 days as part of the detoxification process. In contrast, illicit opioid use in the MMT group remained relatively constant and appeared to decline toward the end of the study (See graph). Such results reaffirm the benefits of continuous methadone administration for moderating opioid abuse and better retention in treatment.



From Sees et al. 2000

• Neither treatment modality was effective in reducing cocaine use. As most past research has demonstrated, methadone is not a treatment for stimulant abuse.

The results of this study are not surprising. Five years earlier, Bell and colleagues [3] had reported that a time-limited abstinence-oriented treatment philosophy resulted in lower, inadequate methadone doses and higher rates of heroin abuse. They concluded that "in investigating the effects of treatment factors, the powerful influence of methadone dose needs to be taken into account."

Where are the Standards?

Sees et al. [2] claimed the methadone doses in their study were "adequate by current practice standards," but they did not reveal the source of those standards. A sampling of commentary from recently reported research studies suggests that standards still do not exist and current MMT practices may be inadequate.

In a study comparing 2 levels of methadone dose, Strain et al. [4] noted: "Despite methadone treatment's extensive history, controversy regarding optimal dosing persists." They observed that "no contemporary studies [that they knew of] have examined doses greater than 80 mg/d." And, although their study had average "high" doses of nearly 90 mg/d, 53% of patients in that high-dose group still exhibited opioid-positive urine tests. The authors conceded that, "It is possible that dosages in excess of 100 mg/d may be required for optimal benefits in some patients." But they also believed that "current federal regulations in the United States discourage methadone dosages greater than 100 mg/d."

A study by Preston et al. [5] sought to improve MMT outcomes by providing vouchers for desired behavior, "since dose increases alone may not always be adequate or *acceptable to clinic staff*" [italics added]. A baseline methadone dose of 50 mg/d was chosen in this study because "it had been reported to be customary in more than half of the programs surveyed in 1988." (However, it actually was noted in that survey by D'Aunno and Vaughn [6] that such doses were totally inadequate.) In one of the groups, a dose increase to 70 mg/d was allowed, but Preston et al. conceded that, "the methadone doses were modest and were not individualized… [which] may have contributed to high overall rates of opiate use…." Part of the rationale behind this study, the authors noted, was that there may be situations in which dose increases are "…impossible for *regulatory or philosophical reasons*" [italics added].

In a large prospective study of more than 1000 MMT patients by Magura et al.[7] high levels of heroin abuse persisted. And, despite limited methadone dose increases, the entire sample population averaged 52 mg/d (± 20 mg/d SD) and only 3% received 90 mg/d or more. The authors acknowledged that "it may be that such upward dosage adjustments [were] simply not high enough to achieve their aim." This same group of researchers later acknowledged that "there are as yet no recognized standards and validated program quality variables in methadone treatment."[8]

The "Science of Under-Medication"

It appears that, even after 35 years, MMT patient care standards are unsettled,

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and burdened by the specter of regulatory control and misdirected treatment philosophies. Certain trends seem evident:

1. Although past research has persistently and consistently reported the value of higher versus lower methadone doses, practically all studies have had maximum dose limits of 100 mg/day and average doses, even in "high dose" groups, have been substantially below that ceiling threshold.
2. Continued opioid abuse in patients – sometimes significantly high percentages – is a common finding in all studies, whether patients are on "high" or "low" doses. Because these studies set an upward limit on dose adjustment, optimum dose for possibly completely alleviating such recidivism is unknown.
3. Although most studies report high attrition rates, patients receiving higher methadone doses exhibit greater retention in treatment. Again, due to the upward limits on dose, it is impossible to know how retention might be maximized further via methadone dose.
4. Patient populations and the drug culture have changed over the years. Large numbers of patients in MMT today have comorbid physiologic and psychiatric disorders for which they are prescribed medications that may affect methadone metabolism. Heroin is purer and cheaper, leading to more dynamic drug dependency. Research studies typically do not account for such variables.

In all fairness, researchers have noted the deficiencies in their studies, as discussed above, but little has been done to remedy the situation. Consequently, much of the research to date might be characterized as defining the "science of methadone under-medication."

Researchers have noted deficiencies in their studies, however, much of the research to date might be characterized as defining the "science of methadone under-medication."

Implications Beyond MMT

In the *USA Today* article,[1] buprenorphine was portrayed as "cutting-edge because it's different from methadone," according to Charles O'Brien, chief of psychiatry at the Philadelphia VA Medical Center. "You almost can't overdose on heroin when you're on buprenorphine," he said. "It's really been a huge success. People can function totally normally and be very alert if it's properly dosed."

"Properly dosed" is an important caveat in O'Brien's statement, for therein may lie a tripwire at the slippery slope. The dosing question may eventually confound newer medications like buprenorphine – or methadone applied in private medical practice – just as it has MMT clinics to this day. And, reductions in federal control over methadone and the newer medications may have little impact if current stigma and biases cannot be overcome.

Upcoming articles in this "MMT & Beyond" series will examine critical questions more closely from evidence-based perspectives. Where did the 100 mg/d methadone dose ceiling come from? What can be learned from the very few studies that have exceeded that threshold? How might desirable addiction treatment outcomes be defined and maximized?

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[Disclosure: This article was sponsored by an educational grant from Mallinckrodt Inc., a manufacturer of methadone.]

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"Clinic Notes"
Continued from Page 1

transition from the current regulatory approach to the proposed accreditation/regulatory approach, SAMHSA's Center for Substance Abuse Treatment (CSAT) developed an ongoing pilot study of an initial cohort of randomly selected MMT programs.

This pilot study was expected to take several years, since it would involve assessing programs prior to the accreditation process, the accreditation survey itself, and follow-up examinations to see if treatment improved as a result. Some programs would serve as controls, providing baseline information but not undergoing the whole accreditation process.

Several organizations are involved in the pilot study. The Research Triangle Institute (RTI) in Raleigh/Durham, NC is conducting assessments from a research perspective. Johnson, Bassin & Shaw (JBS) of Silver Spring, MD has been contracted to provide technical assistance, helping MMT programs prepare for the accreditation survey.

One of two organizations will do the actual surveying and accreditation of MMTPs. CARF (Commission on Accreditation of Rehabilitation Facilities), Tucson, AZ, is a private, not-for-profit organization resulting from the melding of 2 rehabilitation associations in 1966. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Chicago, IL, also an independent, not-for-profit organization, was founded in 1951.

Eventually, each state will be able to chose which organization — CARF or JCAHO — they want to serve as the accrediting body. Or, those states with a large number of MMTPs can choose to serve as their own accrediting agency. Final details are yet to be elucidated.

Devil In Details

Three of the 9 MMT programs sponsored by the Division of Substance Abuse, Albert Einstein College of Medicine, Bronx, NY, are in the midst of the CARF accreditation process. According to Ira J. Marion, Executive Director and Program Sponsor, the 3 clinics were "mock surveyed" last spring. "In May, we started preparing in earnest for the actual site survey by CARF, which is scheduled for the end of this September. We created an oversight committee and have had the equivalent of 2 full-time staff working on this project," he notes.

Marion likes the very strong patient-oriented focus of accreditation. "For exam-

Continued on Page 7

ple, you must meet with patients to determine their satisfaction levels and needs, and all policies must be communicated to them. You also must have organized activities that reduce stigma surrounding treatment."

Accreditation is also good for the staff. "It forces clinic management to clearly communicate duties, responsibilities, and expectations via staff training and development programs," he observes. "And, employees must receive ongoing feedback on their performance."

However, Marion and his team discovered that the "devil is in the details." Although the Albert Einstein program is among the largest in the world, serving 3400 patients, they still had to write numerous new policies and procedures. "Some didn't exist and others needed special wording to comply with CARF criteria," Marion recalls.

There have been concerns about the costs of accreditation and, as Marion learned, it can be an expensive process. "Some believe a full-time employee will be required just to track the quality assurance and improvement processes on an ongoing basis," he says. And, some tasks may be daunting, such as the requirement to collect post-discharge information on at least 10% of persons who leave the program. Yet, this is a population that is very difficult to track over time once they are discharged.

Marion believes that once the final rule is promulgated, the accreditation process could cost an MMT program as much as $10,000 for the survey alone, including the CARF or JCAHO fees and survey preparation costs. Added to that are ongoing costs of maintaining accreditation, such as for a quality assurance manager.

Work In Progress

According to Marion, who also serves on government committees overseeing the accreditation project, there are several potential outcomes of the accreditation survey process. An MMT program may receive a 3-year accreditation, which is most desirable, or only 1-year accreditation and have to repeat the whole process within a fairly short period. Or, a program might be given a 3-month abeyance to correct deficiencies prior to a second survey, in lieu of failing accreditation completely.

Marion observes that writing all the policies and procedures is just the beginning, and it could prove to be a monumental effort for some clinics. He feels that the documentation process would have been much easier had there been already-prepared manuals — a compendium of written materials or "boilerplate" that meet CARF requirements — that could be adapted and customized to individual clinic situations. CARF has a series of guides available for $245 (see Web site listed below), but these do not provide such policies and procedures.

Overall, accreditation should benefit the opioid addiction treatment field and, especially, improve patient care

However, there is much more to accreditation. Surveyors also talk to staff and patients to make certain that what is in writing is communicated and put into practice. For example, staff might be asked if they know what the program's mission statement is; patients might be asked if they are aware of their personalized treatment plans.

At Einstein, considerable effort also was devoted to presenting their program to site surveyors. They developed a slide program to communicate the most information in the shortest possible time. It highlights the history of their program, current organizational structure, service offerings, changes over recent years, demographics of employees and patients, and much more.

In sum, Marion believes the accreditation process is still a "work in progress" and some aspects may need change or refinement. It could be challenging for some clinics but, overall, it should benefit the opioid addiction treatment field and, especially, improve patient care.

Ready In Texas

In Texas, Bobby Glass agrees with Marion that the switch in oversight from the FDA to CSAT, and accreditation, will be good for MMT patients. He is president of Addiction Medicine Associates Inc. and program sponsor of the Brentwood Stair Clinic in Fort Worth, serving 427 patients. His clinic is part of the control group of MMTs being assessed by the RTI, but not undergoing the accreditation survey at this time.

He believes that, in Texas, clinics already have fairly well-developed written policies and procedures as mandated by state authorities. "I doubt that my clinics [he has a second clinic in Denton] will have to make many changes. We have good documentation, good counselors, and good patient care treating everyone with dignity and respect."

Still, Glass expects that under an accreditation system he might have to hire an additional person, possibly just to audit charts. "That's not necessarily a bad thing," he says, "although accreditation will probably create more paperwork."

However, Glass suspects that many clinics in other locales may not operate under the tight regulation found in Texas. "Some of the records I see of patients transferring to us from other states are not in very good shape," he observes.

Worth The Effort

Glass feels some aspects of the proposed rule may need modification. For example, it will be good if patients can qualify for 6-day take-home doses after only the first year in treatment, but he feels that eventually giving up to 30 days of take-homes is concerning. "Patients might be tempted to abuse that privilege by self-medicating with extra doses if they are in pain or become ill," he says.

He noted that Texas clinics will have the option of deciding whether CARF or JCAHO would be selected as their accrediting organization. He estimated it could cost up to $8,200 just for the accreditation process, not including added staff and administrative time or costs of improvements.

"If this accreditation process brings the deficient clinics — those that give MMT a bad name — up to higher standards, then I'm all for it," he stresses. "Even if it does take a bit more money and effort." Glass concedes, however, that the added costs of accreditation, improvements, and ongoing administration may need to be passed on to patients or their insurance providers.

For more information on the accreditation process, visit the following Web sites:
CARF: www.carf.org/BehavioralHealth/OpioidTreatment.htm
JCAHO : www.jcaho.org/standard/bhc_supp/bhc_frm.html.

A.T.F.

Reader Survey Results

Addiction Treatment & Sexual Disorders

An article in the spring 2000 edition of *AT Forum* – "Sexual Dysfunction & Addiction Treatment" – noted that a great many patients entering addiction treatment may have sexual difficulties related to their lifestyles and substance abuse. Readers were asked, "What percentage of patients do you estimate experience sexual disorders?" There were 102 responses via www.atforum.com or feedback card, and 82 persons provided complete information for analysis.

The results are (mean ± SD): sexual disorders prior to treatment, 60.3 ± 27%; during treatment, 60.6 ± 26%; and, following treatment, 41.4 ± 26%.

Obviously, improvements noted during treatment were not remarkable; however, enhancement of sexual function posttreatment was significant ($p<0.001$). Of those responding to the survey, 67% were clinical staff, although there were no significant differences in the estimates of this group compared to patients who responded.

Due to the lack of significant change noted during treatment, it appears likely that few addiction treatment programs address sexual disorders as part of therapy. Improvements following participation in treatment may be a natural outcome of improved lifestyle and abstinence from substances that disrupt hormonal balance. It should be noted, however, that the responses were probably based more on perception than any actual reviews of medical records. Estimates of sexual disorders ranged from 2% to 100% and the statistical standard deviations were quite large, whether pretreatment, during, or posttreatment.

Respondents also were asked which drugs most patients were addicted to before treatment. Answers were: 72% heroin (+11% other opioid), 55% cocaine/crack, 33% alcohol, 9% methamphetamine, and 8% benzodiazepines.

According to the *AT Forum* article, up to 87% of heroin addicts may have sexual difficulties while using opiates and 22% may continue to have such problems during methadone maintenance treatment. However, looking only at the 58 survey responses indicating heroin as a pretreatment drug of choice, the answers were almost identical to the overall impressions: roughly 62% experienced sexual difficulties before *and* during treatment, and 42% afterward.

Several respondents offered comments:

"I think [sexual dysfunction] happens more than patients admit." – patient.

"The medications used to treat depression (which I and many other patients suffer) cause sexual disorders, if the problems weren't there before." – patient.

"Very few men admit to sexual disorders. Many of the women who discuss such issues indicate they escalated sexual activity with drug use, seemingly as a reaction to previous sex abuse." – staff member.

"My estimates are minimum percentages and are based on those having brought up the subject as a problem. Few acknowledge the possibility of substance abuse as a source of sexual dysfunction." – staff member.

"[Sexual disorders] are not readily identified because they are not assessed by clinicians and/or patients fail to provide adequate information. Addictions help people avoid feelings and intimacy, which are essential for healthy sexuality. Treatment may escalate the realization of fears that hinder sexual function temporarily. As recovery continues, healthy relationships and sexuality will develop." – staff member.

The data from this survey suggest that there is a large variation in what is occurring and/or identified across individual treatment programs. Apparently, sexual health may be a neglected area of patient concern requiring further consideration and action.

A.T.F.

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