

Forum

THE QUARTERLY NEWSLETTER FOR CLINICAL HEALTH CARE PROFESSIONALS ON ADDICTION TREATMENT

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Patients should be able to receive at one place all the services they need to help them in addiction recovery.

IN THIS ISSUE

| | |
|---|---|
| "One-Stop-Shop" for Addiction Treatment | 1 |
| Fates of Buprenorphine, MMT Intertwined? | 1 |
| Events to Note | 2 |
| From Editor... Treatment Contracts? | 2 |
| New Survey: MMT Contracts? | 3 |
| Lessons from Vincent Dole, MD | 3 |
| Treating Chronic Pain in MMT Patients | 6 |
| Opioid-Induced Constipation Myths | 7 |
| Survey Results: Methadone in Jail/Prison? | 8 |

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Program Pointers

"One-Stop-Shop" for Addiction Treatment

CRC Moves Toward the Future

For a number of years, SAMHSA (the U.S. Substance Abuse and Mental Health Services Administration) has emphasized the concept of "no wrong door" when it comes to mental health and addiction treatment services. That is, persons in need should be able to receive all of the services they need to help them in recovery at a single facility – serving as sort of a "one-stop-shop."

So far, this largely has been an unrealized dream. However, when it comes to addiction treatment, one organization – CRC Health Group, Inc. – is working toward making that a reality.



CRC HEALTH GROUP, INC.

AT Forum spoke with Philip L. Herschman, PhD, president of CRCs OTP (Opioid Treatment Program) Division headquartered in California. A clinical psychologist, he has more than 30 years in the mental and behavioral healthcare fields and joined CRC nearly 5 years ago.

Rapid Growth in Facilities & Patients

The CRC organization may be leading a nationwide trend in the addiction treatment field, and growing rapidly via acquisition of existing clinics.

The firm was founded in 1995 when it acquired a residential treatment facility in Northern California called Camp Recovery Center; hence, the CRC initials, which no

Continued on page 4

Current Comments

Fates of Buprenorphine, MMT Intertwined?

For decades there has been a desire to close the gap between the need for effective opioid-addiction treatment and its availability. The approval of buprenorphine maintenance therapy in 2002 for this purpose, joining methadone maintenance treatment (MMT), was greeted with great optimism in some quarters and trepidation in others.

If MMT's past is predictive of buprenorphine's future, there may be much to worry about. Indeed, the fates of both modalities for treating opioid addiction may be intertwined in ways that few suspect.

Expanded Treatment Needed

A recent review by Robert G. Newman, MD,[1] explored linkages between the past growth of MMT and the present status of buprenorphine maintenance therapy. Newman – director of The Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center, New York – helped pioneer the extensive adoption of MMT in New York City.

More than 30 years ago, in the early 1970s, MMT expanded swiftly and was declared a "success," Newman recalls. Yet, growth of both MMT clinics and numbers of patients treated quickly stagnated; then as now, MMT is available to only about 1 in 5 persons with the disease of heroin addiction.

He notes that about 36,000 patients in New York City receive MMT today, out of an estimated 200,000 heroin-dependent persons; compared with 34,000 MMT patients in 1974. However, today there also is the threat of

Continued on page 5

Events to Note

For additional postings, including international meetings, see: www.atforum.com

October 2006

American Academy of Child & Adolescent Psychiatry 53rd Annual Meeting

October 24-29, 2006

San Diego, California

Contact: 202-966-7300; www.aacap.org/

2006 National Council on Alcoholism and Drug Dependence (NCADD) Conference

October 25-28, 2006

Milwaukee, Wisconsin

Contact: 212-269-7797; www.ncadd.org

ASAM Review Course in Addiction Medicine

October 26-28, 2006

Chicago, Illinois

Contact: 301-656-3920; www.ASAM.org

November 2006

Association for Medical Education Research in Substance Abuse (AMERSA) 30th National Conference

November 2-4, 2006

Washington, DC

Contact: 401-349-0000; www.amersa.org/

American Public Health Association 134th Annual Meeting

November 4-8, 2006

Boston, Massachusetts

Contact: www.apha.org/meetings/

Canadian Psychiatric Association 56th Annual Meeting

November 9-12, 2006

Toronto, Ontario, Canada

Contact: 800-267-1555; www.cpa-apc.org/

6th National Harm Reduction Conference

November 9-12, 2006

Oakland, California

Contact: 212-213-6376;

<http://harmreduction.org/6national/>

Association for Behavioral & Cognitive Therapies (ABCT) 40th Annual Convention

November 16-19, 2006

Chicago, Illinois

Contact: 212-647-1890; <http://www.aabt.org/>

December 2006

American Academy of Addiction Psychiatry

December 7-10, 2006

St. Pete Beach, Florida

Contact: <http://www.aaap.org/>

[To post your event announcement in AT Forum and/or our website, fax the information to: 847-392-3937 or submit it via e-mail from www.atforum.com]

Straight Talk... from the Editor

Treatment Contracts for MMT Patients?

A recent storm of debate raged in Scottish newspapers over a politically-motivated proposal that patients entering addiction treatment should be required to sign a "social contract." That is, in return for methadone maintenance treatment (MMT) and other benefits they must agree to end their illicit drug use and not have children.

This was spurred by tragedies involving children in the care of drug-addicted parents. Interestingly, the impetus for what some considered outlandish demands came from an American scheme several years ago whereby female illicit-drug users were offered cash in exchange for entering drug treatment and taking long-term contraceptives.

Although, those measures were argued against for numerous reasons both in America and Scotland, it did inspire a reconsideration of the possible value of addiction treatment contracts; not as a threat, but as mutually beneficial agreements between healthcare providers and persons entering treatment.

There is some precedent for this in MMT as well as in other areas of medicine, such as pain management.

Rx Opioid Contracts Common

The use of "Opioid Contracts" – written agreements between physicians and patients concerning the prescription of opioid drugs for pain – is fairly common among pain specialists and many primary care physicians. It is believed that commitment to these contracts can potentially improve the therapeutic relationship; however, their effectiveness in actually ensuring patient compliance with prescribed regimens is largely undetermined.

Most opioid contracts broadly specify the goals and risks of treatment, expected and prohibited patient behaviors, and potential reasons for treatment termination. Along with that, the obligations of treatment providers and rights of patients to receive adequate care also are clearly stated.

Some pain practitioners believe these contracts protect them from liability, especially from regulatory censor if the drugs they prescribe are misused or diverted. However, commitments to patients must be met and physicians have been found legally liable for not honoring contract terms.



MMT Contracts: Rights & Responsibilities

Similarly, within MMT programs, treatment contracts might serve to improve therapeutic relationships by defining rights and responsibilities.

Federal regulations require that each patient sign an informed consent for participation in MMT. This includes information about confidentiality, as well as program policies, procedures, and services. However, this and other routine admission paperwork are not the same as an MMT contract.

An MMT Contract (or Agreement, as it is sometimes called) extends beyond the usual administrative considerations. In a contract, both parties – patient and clinic staff – commit to a plan of action and share common visions of success within a time frame of some sort. The document typically includes sections describing...

- **Patients' responsibilities** – in adhering to rules and participating in the therapeutic process, along with stated consequences for misbehavior or non-compliance.
- **Patients' rights** – including how they can expect to be fairly treated and what privileges may be earned; and, if necessary, how to protest mistreatment or appeal staff decisions.
- **Clinic/Staff responsibilities** – include how patients are to be treated and how treatment itself is to be delivered, assessed, and modified as appropriate for individual needs.

Government regulations do not mandate MMT contracts. However, other organizations, such as the College of Physicians of Ontario and some progressive MMT programs, have developed and implemented MMT contracts. To date, there does not appear to be any research on their effectiveness in improving treatment outcomes.

Ethical & Enforcement Dilemmas

Regarding either MMT or pain management, there is the nagging question of when treatment contracts should be initiated. During the anxiety-filled atmosphere of entering treatment a person may not be in a state of mind to carefully assess a contract, weighing pros and cons, and providing well-informed consent.

Continued on page 3

And, although the contract might be presented as voluntary, in the spirit of mutual trust, the clear implication is that treatment will be refused or discontinued unless it is signed by the patient. So, coercion is substantial and ethically troublesome.

Enforcement also is problematic. There always is the possibility that the patient can be discharged from treatment for noncompliance. This might relieve MMT clinics of blame by claiming, "The patient knew the contract terms and brought it on himself."

Still, the consequences of returning drug-addicted persons to the streets or denying them medical care can be severe. In this day of HIV/AIDS and other communicable diseases it would create more problems than it solves.

Furthermore, an equitable contract specifies MMT staff responsibilities. If they fail to fulfill conditions of the contract, patients might initiate legal actions to obtain promised treatment.

So, like methadone itself, MMT contracts have potential to do great good, as well as possible harm if misused. We welcome comments from our readers and also encourage participation in our survey on this subject (see below).

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NEW SURVEY: MMT Contracts?

As a followup to the editorial in this issue, please respond to the following survey questions:

1. Do You believe MMT patient contracts are... Helpful; Harmful; Unnecessary.
2. Does your MMT clinic have patient contracts? Yes; No; Don't Know.
3. When should a treatment contract be signed? During admission to MMT; After stabilization on methadone; Never; Other (specify) _____.
4. Are you responding as an MMT patient, or MMT clinic staff member?

There are several ways to respond to AT Forum surveys: A. provide your answers on the postage-free feedback card in this issue; B. write, fax, or e-mail [info above]; or, C. visit our website to respond online. As always, your written comments are important.

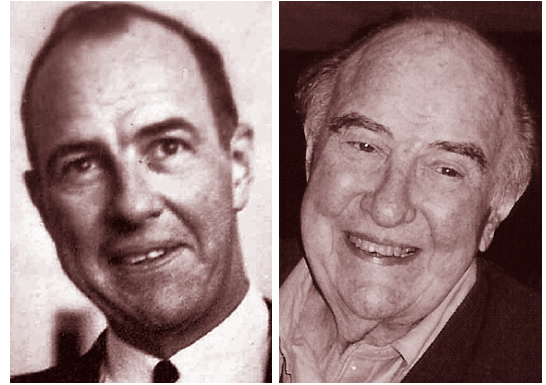
Lessons from Vincent Dole, MD

Last August 2006, Vincent Dole, MD, died at age 93. He was widely praised as the "Father of MMT (methadone maintenance treatment)"; above all, however, he was an accomplished scientist, a mentor to many in the addiction treatment field, and a champion of patient advocate groups.

Following his death, tributes appeared widely in the press, sometimes referring to Dole as a "gentle giant." *AT Forum* had featured him in our Spring 2005 edition, which is available online at http://www.atforum.com/SiteRoot/pages/current_pastissues/spring2005.html. He personally approved that article, and it was the last time we spoke with him – for he was still mentally bright but physically fading. While gathering information, we also had an opportunity to become acquainted with his charming wife, Margaret, to whom we express our sincere condolences.

During the 14 years of *AT Forum*, Dole became a cherished supporter of this publication and an occasional behind-the-scenes advisor. Here is the essence of several enduring lessons learned from him through the years:

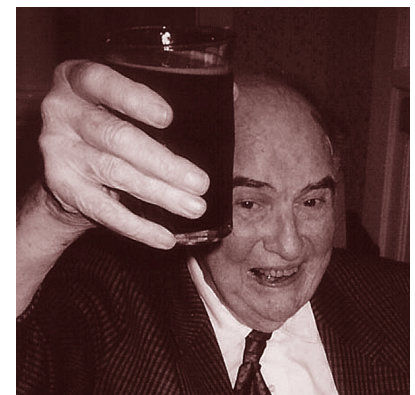
- Substance dependence – addiction – is foremost a chronic, relapsing medical *disease*, rather than simply a moral, mental, or behavioral problem.
- Methadone is only a medication; it is one component of a treatment program for opioid addiction and does not cure the disease, so it may be required for a lifetime.
- Other medical treatments for opioid addiction should be considered; however, they must be thoroughly grounded in valid evidence coming from extensive clinical research.
- Above all else, practitioners must *listen to their patients* when it comes to providing effective care – a vital lesson that he always credited to his colleague (and wife at the time) in developing MMT, Marie Nyswander, MD.



Sadly, Dole always expressed to us his disappointment that so many in the medical field, as well as the general public, did not truly accept addiction primarily as a medical disorder. Optimistically, he believed that experience and scientific evidence would bring more rational and effective ways of treating all addictions; although, he conceded that if the persistent stigma and prejudice surrounding MMT are any indicator, society is still lacking the open-mindedness to accept the lessons of science over outdated beliefs.

We always sent to Dole copies of *AT Forum* newsletters and special reports. Several times he called to express his approval or discuss a point of interest. And, always the mentor, he would never miss an opportunity to say something like, "Did you know that on page 4, paragraph 3, there's a typo? Consider that my contribution to the writing!"

Listening to him, learning from the master, was always a humbling experience; but never humiliating because, after all, he indeed was a *gentle giant* in the field of addiction medicine. In spirit, we join Dr. Dole in a salute to medical science and its eventual conquest of the disease of addiction.



longer stand for the original facility or any other words. Today, there are 2 divisions – ROF (Residential and Outpatient Facilities) and OTP – comprising a total of 90 facilities in 21 states.

Herschman notes that the rapid growth of his OTP division began about 5 years ago, expanding to 52 facilities in 16 states since then and currently serving more than 22,000 patients each day. The largest concentration of facilities is in California, with 13, and plans are to start 6 new clinics and acquire another 6 this year (2006).

CRC is privately held. Besides top management the only outside investor is Bain Capital, a private equity firm that acquired CRC in February 2006. Going public is clearly an option during the next 3 to 5 years, but there currently are no plans for this, according to Herschman.

Consolidation Has Its Benefits

Consolidation of smaller independent operations seems to be a trend in behavioral healthcare, which Herschman believes is a positive development that is good for the field. For example, he says, "Because of our size we have the ability to move treatment a giant step forward, such as being able to implement high quality standards throughout our organization."

"Too often, in the addiction field, the treatment an individual patient receives is based on the philosophy of the particular clinic and the skills of the individual healthcare provider," he continues. "It's not always based on an objective assessment of patient needs and current best practices."

When a clinic is acquired, current management usually stays in place, but CRC has standardized operating manuals based on the firm's evidence-based approaches, and these are reinforced through rigorous training. "We have trainers on staff who visit our various clinics," Herschman notes. "We also have self-tutorials allowing clinic staff to log onto the CRC Intranet for self-paced learning, and there is Internet-based training with instructors conducting live training events simultaneously all over the country."

Many patients will require therapy with medications such as methadone-maintenance treatment (MMT) for a lifetime. But it is difficult to distinguish those who do from those who do not.

All CRC OTP clinics are CARF accredited, and CRC quality-management coordinators visit every clinic at least twice each year. They spend 3 to 4 days examining operations and correcting any deficiencies on the spot. "So, to the extent that we reinforce and provide science-based interventions, I think we've taken treatment to a higher level and can have more successful outcomes," Herschman asserts.

Enlightened Perspective

"We view all addictions as chronic diseases, and many of our clinical programs are derived from that enlightened perspective," Herschman says. "Rather than short episodes of treatment, we see the need to maintain ongoing contact with patients and being able to refer them to appropriate interventions as needed at different points in time. We cannot think of substance addiction like we think of a broken leg, in which the problem can be fixed by a relatively brief treatment intervention."

For opioid addiction, many patients will require therapy with medications such as methadone-maintenance treatment (MMT) for a lifetime. And, while this might not be true for every patient, "at this point in time it is difficult to distinguish those who do from those who do not require continuous medication," according to Herschman. Furthermore, CRC does not impose any ceilings on methadone doses; whatever amount each patient requires is most appropriate.

Still there are some persons who will not seek MMT if they believe they will be taking methadone for a lifetime. "At any point in time, if a patient says 'I want to be withdrawn from methadone,' we will start a gradual process of reducing the medication, along with intensified counseling to help increase success," Herschman notes.

CRC also has a 2-year maintenance-to-abstinence program. "The patient comes into the clinic and is induced onto methadone in the usual way and stabilized at an adequate dose for a year, with intensified counseling," he says. "Then there is a gradual medically supervised withdrawal of methadone, taking 6 months or whatever length of time works best for the patient."

"This is followed by several months of continuing care, in which the patient still comes to the clinic on a regular basis and makes contact with staff. So, this is a way of engaging those people in MMT who otherwise would not be interested. We believe it is a successful approach and our statistics will verify over time if that is the case."

Research Orientation

CRC has a strong research orientation; although, Herschman concedes, "We don't have a research group. We just believe it is important to objectively know what sort of job we're doing."

"We have been testing an approach in which every 30 days the patient completes a shortened version of the ASI (Addiction Severity Index) questionnaire. This provides immediate feedback to staff on a patient's progress relative to the treatment plan. And, even following discharge, we want the patient to continue with monthly ASI assessments. Our plan is to continue this for 5 years post-discharge and the patient will receive special counseling for any problems that are detected."

Herschman comments that this approach provides objective feedback during the course of treatment, as well as ongoing clinical contact with the patient after discharge. Appropriate interventions can be provided when and if necessary. "It also provides us with outcome data on our performance in effectively helping patients and it can help us to improve our interventions over time."

Focus on Opioid Addiction

"Right now we just treat opioid addiction in our clinics, and primarily with methadone," Herschman notes. Additionally, they offer buprenorphine maintenance when allowed by the particular state.

"We view buprenorphine as an alternate treatment intervention, but it needs to be used appropriately," he adds. "The research



suggests that a patient who has not been illicitly using opioids for a long time or in large quantities, and is younger, might benefit most from this medication. Although, the cost of buprenorphine is sometimes a barrier."

Most CRC patients, roughly three quarters, self-pay for MMT or buprenorphine therapy. Sometimes other sources – private insurance, public aid, or other third-party payers – will cover the costs, but this varies throughout the country. "We've had some success with managed care programs in arranging for MMT payment, and in certain states MMT is covered to some extent by their version of Medicaid," Herschman notes.

Expansion On The Horizon

The latest concept in development at CRC is COSAT – Comprehensive Outpatient Substance Abuse Treatment. This would truly achieve a "one-stop-shop" approach.

"By the end of this year," Herschman continues, "we want to be able to treat *any* drug addiction – with appropriate medications and psychosocial therapy services – on an outpatient basis in the same facility. Additionally, we want to offer outpatient detoxification for all substances, including alcohol, cocaine, amphetamines, and others."

CRC is in the process of obtaining the appropriate licenses and certifications to provide more than MMT services at 70% of their OTP clinics. The major barriers have involved regulatory approvals. Relatively few programs around the country offer treatments beyond methadone and, recently, buprenorphine; in most states, going beyond that is a new concept, so it can be difficult to expand services to other areas of addiction treatment, according to Herschman.

"Presently, MMT programs deal with problems of multisubstance abuse within the context of the counseling taking place in clinics," he says. "However, we're looking at not only our existing patients who might benefit from an expansion of addiction services, but also serving an expanded patient population. These are people who can benefit from the best of what evidence-based science in the field has to offer in terms of medications, healthcare, and counseling services – no matter what substance is involved."

Pain treatment is another business that he believes might be worthwhile for CRC expansion. At present, CRC MMT clinics are not equipped to comprehensively deal with pain management.

"There is such a crossover between addiction and pain that we believe it's a natural move for us," Herschman states. "We're considering a treatment model to handle that on an outpatient basis."

HIV/AIDS and thousands of additional persons addicted to opioid analgesics, so the need for more treatment options has never been greater.

Buprenorphine may help. This medication, an effective analgesic (as is methadone), has been in use since the late 1970s. During 2 decades of clinical research buprenorphine maintenance therapy was demonstrated as helpful for treating opioid addiction; or, at least as effective as methadone, in some patients and in certain circumstances.

Unfortunately, controlled clinical trials often fail to clearly define exactly which patients can benefit most from a therapy when it comes to everyday medical practice in diverse settings. This is a concern with buprenorphine, and only time will tell where, when, and in whom it works best.

Impressive Outcomes Data

Last spring, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) released some impressive statistics regarding the adoption of buprenorphine.[2] During the early years following its approval for addiction therapy in October 2002 the number of sites and physicians offering the treatment grew rapidly, as expected.

By the beginning of 2005 there were about 2,800 physicians approved to use buprenorphine (received waivers), half of whom had not previously provided therapy for opioid addiction, and two-thirds were prescribing the medication. The largest number of those prescribing buprenorphine, nearly 1,200, were in individual private practices. Fewer than 400 were in existing opioid-addiction treatment settings.[2]

By March 2005, SAMHSA estimated that a cumulative total of 104,600 patients had received buprenorphine since its approval; about a third received the medication as part of an opioid detoxification regimen rather than ongoing maintenance. Roughly 60% of all patients were primarily addicted to or abused non-heroin opioids and a third of them suffered from chronic pain conditions.[2] This is important, because there are significant numbers of pain patients abusing opioid analgesics and they may represent a major subpopulation who might benefit from buprenorphine.

While some may question the data, 6-month treatment outcomes reported by SAMHSA are noteworthy. During the 30 days prior to being surveyed, about 60% of patients self-reported abstinence from all

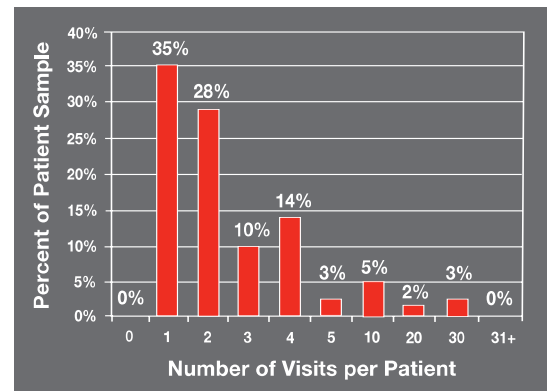
substances of abuse and 80% were abstinent from all opioids (except prescribed buprenorphine). At the same time, retention rates were 71% to 77% (depending on primary substance of prior abuse), with reported increases in employment and decreased criminality.[2]

Few of the prescribing physicians believed their patients would have sought MMT for their addiction and most perceived buprenorphine to be most effective during longer-term treatment. Buprenorphine appeared to be somewhat more effective for patients primarily addicted to prescription opioids rather than heroin.[2]

Relaxed Regulations

At least some of buprenorphine's success, and its potential for failure, hinges on relaxed federal regulations. Newman commented that, since the beginning of MMT, individualized care and comprehensive ancillary services have been recognized as essential components to ensure addiction recovery, which requires intensive staff training and extended time in treatment.[1]

Although the regulatory demands placed on MMT clinics are undiminished to this day, any physician can become certified to prescribe buprenorphine for addiction after only 8 hours of training (now even available online). And, addiction counseling and ancillary services are not mandated components of buprenorphine therapy.



Buprenorphine can be prescribed for a full month, and in some states the prescriptions are refillable without physician contact, Newman notes.[1] Indeed, SAMHSA's survey data show that during the first month of buprenorphine therapy nearly three-quarters of patients see the prescribing physician 3 or fewer times; more than a third go only once [see *Graph*]. Forty-one percent receive no counseling at all, and the majority of patients (about 70%) receive 0 to 4 counseling sessions.[2]

On the other hand, entry-level MMT patients must attend a clinic at least 6 days per week for observed dosing. Along with

that, they must frequently attend counseling sessions and have drug monitoring.

It seems reasonable that buprenorphine therapy would appeal to many opioid-addicted persons, if they can afford it. However, its long-term effectiveness as an addiction treatment might be in doubt, and Newman questions whether this is good medical practice for dealing with a chronic, relapsing disease to begin with.[1] Still, in balance, the SAMHSA survey data [2] demonstrate positive outcomes for buprenorphine therapy; at least relatively short term.

Formidable Barriers

Despite the 'conveniences' of buprenorphine therapy, Newman believes there are formidable barriers to its widespread acceptance. "We can hardly expect physicians, patients or the public at large to embrace treatment with one medication (buprenorphine), when Government itself continues to reflect and reinforce the stigma toward treatment with another medication (methadone) for the same patients and the same disease," he writes.[1]

Newman expresses the perspective that the overabundance of regulations and prejudices surrounding MMT serve to taint the whole field of opioid-addiction treatment, and the stigma naturally carries over to buprenorphine. An implication is that, "mainstream medicine" would largely stay away and those providers who do become involved in prescribing buprenorphine must consider the discomfiting possibility that at some point in time their practices may come under government-imposed restrictions similar to those for MMT. Especially, if buprenorphine fails to deliver on its promised success.

Therefore, the concern should not be that buprenorphine will draw patients away from MMT – for there are plenty of patients in need of treatment. The real danger is that, after all the promotion and government-sponsored support, if buprenorphine maintenance therapy fails it will reflect negatively on opioid-addiction treatment in general, including a further stigmatization of MMT. A jaded public and exasperated policymakers may well turn their backs on treatment, as they have in the past, and refocus their attention on the criminalization of opioid addiction.

1. Newman RG. Expansion of opiate agonist treatment: an historical perspective. *Harm Red J.* 2006;3:20+. Available online at: <http://dx.doi.org/10.1186/1477-7517-3-20>. Access checked 8/26/06.

2. Stanton A, et al. Expanding treatment of opioid dependence: Initial physician and patient experiences with the adoption of buprenorphine. Presentation at American Society of Addiction Medicine, Annual Conference, May 5, 2006. Available online at: http://buprenorphine.samhsa.gov/ASAM_06_Final_Results.pdf. Access checked 8/26/06.

Clinical Concepts

Treating Chronic Pain in MMT Patients

Effective treatments for either acute or chronic pain in patients attending methadone maintenance treatment (MMT) programs continue to be debated. A recent article in the Spring 2006 issue of AT Forum [1] discussed the use of opioid analgesics for the treatment of acute pain in MMT patients, and recommended short-acting agents.

However, that article did not address effective treatments for patients in MMT who experience chronic pain. Regarding that, for this current article, AT Forum interviewed Philip Paris, MD, a clinician with 20 years of experience providing family practice care for patients in an MMT program. He shares his views about appropriate analgesic therapy for chronic pain in this patient population.

Long-Acting Opioid Analgesics Are Best

The treatment of pain – acute and chronic – in MMT patients is so widely debated that experts cannot even agree on the prevalence of it in the chemically dependent patient population, a subject addressed in previous articles in *AT Forum* (Winter 2004[2] and Summer 2005[3]).

Some recent studies estimate the prevalence of chronic pain – lasting 3 months or longer – among patients in MMT programs to range from 37%[4] to 55%.[5] These figures suggest that a much larger percentage of MMT patients experience chronic pain than in the general population; estimated to be approximately 23% of adults in the U.S. with chronic pain.[4]

Chemically dependent persons who experience chronic pain seek relief for it like any other patients would. However, because they have a past history of substance abuse, MMT patients cannot always get their pain medication needs met, particularly if those needs are for long-lasting pain.

As former Director of Medical Services at the Mount Sinai Narcotics Rehabilitation Center in New York City, Paris routinely treated MMT patients in chronic pain with a long-acting opioid, such as morphine sulfate in slow-release tablets, because this provides continuous relief. "Short-acting opioids offer only intermittent relief, which is insufficient for someone in chronic pain," notes the physician who last year retired from his position at Mount Sinai after 20 years.

Although Paris acknowledges there are safety concerns regarding the potential

additive effects of a long-acting opioid analgesic added to the methadone maintenance regimen for treating opioid addiction, he believes it is safe as long as the opioid analgesic is started at a low dose and gradually built up, or titrated. Additionally, patients should be observed over several visits to determine how they are responding to the medication and if they are experiencing any side effects.

He explains to patients that it will take time to build up to an adequate dose for optimal pain relief, but that this gradual approach is used for the patients' own safety. Among the safety concerns of taking long-acting analgesics in addition to methadone are the development of respiratory depression and increased somnolence, as well as the potential for abuse.

With regard to the latter, Paris believes another benefit of using long-acting opioids is that there is less chance of them being abused by the patient or others looking to buy drugs on the street. That is because the long-acting opioids do not spike in the bloodstream (thereby producing euphoric effects) as quickly as short-acting ones, he explains.

Gradual Titration Essential

The key to using long-acting opioids safely is to titrate the dose gradually. Typically, Paris starts with a low dose of 30 mg of a long-acting morphine sulfate tablet, given twice a day. He does not increase the dose more than once a week. The maximum dose Paris titrates to is 400 mg; that is, 200 mg taken twice daily. The usual dose of methadone does not require any adjustment when initiating treatment of the patient's chronic pain, he adds.

Titration to an effective dose in this manner may take a month or longer, says Paris. "But as the patients are gradually getting relief from their longstanding pain problem, they're satisfied." Additionally, they have a physician willing to work with them, which is important because as Paris notes many MMT patients also have chronic illnesses, such as high blood pressure, diabetes, and arthritis. "These conditions require the patients' full participation for successful treatment and if they believe in me, as I believe in them, the treatment for all their illnesses becomes much easier," he notes.

Paris also is a proponent of using scheduled, rather than PRN (anytime as

Continued on page 7

needed), dosing. "For chronic pain, you want the patient to be on a regular schedule," he says. "You don't want him or her to have intermittent pain."

Anti-depressants and anti-seizure drugs, which are sometimes used to help increase the effects of the opioid analgesics, are not part of Paris' regimen, either. Not only do those have their own set of side effects, but some of the anti-seizure medications (for example, carbamazepine or phenytoin) interfere with serum methadone levels, he says. When the results of his approach are inadequate, Paris refers patients to a pain management clinic where the ancillary medications are often employed.

Breakthrough Pain Downplayed

A recent study indicated that breakthrough pain – that is, pain that overwhelms or "breaks through" the relief normally afforded by ongoing analgesics – is a problem for nearly three-quarters of patients with chronic noncancer pain.[6] However, Paris is not in favor of treating so-called "breakthrough pain." He does not address this issue with his MMT patients because he says his goal is not necessarily to eliminate all of the pain. On a pain scale of 0-to-10, most patients start with levels of chronic pain between 8 and 10. "If we can bring that down to 2 or 3, they are happy," he says. "And yes, they still have some aches, but those are not disabling. The pain does not dominate their lives, they can function."

If, however, the patient is experiencing severe pain between appointments, Paris will increase the dose of the long-acting opioid. "But I do not supplement the long-acting opioid medication with short-acting analgesics," he asserts, acknowledging that his viewpoint may depart from common practice.

Unwarranted fears of reawakening addiction by treating MMT patients with opioid analgesics has led to their undermedication.

Undermedication Issues

In all his years of treating MMT patients for chronic pain using long-acting opioids, Paris has not seen any patients relapse to opioid abuse. Still, the misconception that physicians can create or re-awaken a patient's opioid addiction by treating them with opioid analgesics for pain, he believes, has led to the undermedication of MMT patients.

Another factor contributing to "opiophobia" (the tendency of providers to undermedicate patients with opioid analgesics) is that pain is subjective, requiring doctors to accept pain based on the patient's report. Although physicians make every effort to establish the true origin of the pain, he says, it is not possible to be sure any particular patient is telling the truth.

However, Paris would rather err on the side of believing his patients. "I am not going to withhold pain treatment from all of the patients who need it just because somebody might fool me sometime," he says.

Paris learned that lesson early in his career when he began treating a man for chronic chest pain following thoracic surgery. After two years of treatment, Paris told the patient that it was time to stop treatment, even though the patient claimed to still be in pain. Without taking into account a prior history of alcoholism, Paris took the patient off the pain medication and the man began to self medicate with alcohol. The patient ended up hospitalized with severe inflammation of the pancreas and almost

died. After the patient was discharged, Paris resumed the patient's pain management program.

How physicians view their MMT patients is critical to providing them appropriate medical care, he adds. "If you view the patient as basically untrustworthy, as somebody who is always trying to put something over on you," concludes Paris, "then you are going to withhold many treatments, including those for pain management."

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Ruth Carol, a Chicago-based freelance writer specializing in healthcare issues, conducted this interview for AT Forum.

Opioid-Induced Constipation Myths Dispelled

Constipation is a frequent, many believe inevitable, side effect of all opioids, including methadone, buprenorphine, morphine, etc. These agents naturally slow activity (peristalsis) in the gastrointestinal tract.

A new research report from *Pain Treatment Topics*, called "Managing Opioid-Induced Constipation in Ambulatory-Care Patients," notes that effective prevention or treatment of constipation usually requires laxatives; most commonly a combination stool softener and stimulant. Bulk-forming laxatives must be avoided in opioid-induced constipation, because intestinal blockage might occur due to inhibited peristalsis.

The report also dispels common myths about constipation. For example, available evidence does not indicate that opioid-induced constipation can be helped merely by increasing intake of fluids or dietary fiber, unless the patient is already dehydrated or consuming a fiber-deficient diet. Similarly, increasing activity or exercise is of limited value in dealing with opioid-induced constipation and may be inappropriate for many patients with pain.

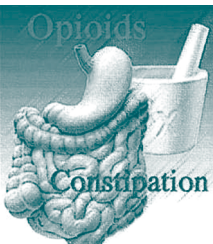
The 9-page report is available for free download at Pain-Topics.com (under the "Opioid Rx" tab) or http://www.pain-topics.com/opioid_rx/index2.php#constipation.

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Managing Opioid-Induced Constipation in Ambulatory-Care Patients

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| | |
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| Contents | |
| Introduction | 1 |
| Functional Constipation | 2 |
| Opioid-Induced Constipation | 2 |
| Prevalence | 3 |
| Role of Opioid Receptors | 3 |
| Differential Opioid Effects | 3 |
| Patient Assessment & Treatment | 4 |
| Prevention | 4 |
| Non-Pharmacologic Tx: Myths & Facts | 4 |
| Pharmacologic Tx: Laxatives | 5 |
| Alternative Pharmacotherapies | 7 |
| Opioid-Receptor Antagonists | 7 |
| Selective Antagonists | 7 |
| Prokinetic Agents | 7 |
| Summary | 7 |
| References | 8 |



Introduction

Constipation is a frequent side effect of opioids since these agents decrease peristaltic activity in the gastrointestinal (GI) tract. Because of the mechanisms involved in opioid-induced constipation, some treatments that may be applicable for common, functional constipation are inappropriate for ambulatory-care patients prescribed opioid analgesics.

Also in these patients, the distress of constipation may add to the discomfort already present from pain, and they might decrease or discontinue the opioid to avoid constipation. So, motivating such patients to comply with their opioid therapy also requires a special approach for managing constipation.

Constipation as a potential side effect whenever an opioid medication is prescribed.

Survey Results: Methadone in Jail/Prison?

As a followup to an article in the *AT Forum* Winter 2006 edition (Vol.15, No. 1) on "MMT in the Criminal Justice System," readers were surveyed on their experiences. There were 192 individuals responding, and the vast majority (72%) were clinic staff members.

Nearly all respondents (91%) reported that their MMT (methadone maintenance treatment) clinics had patients who were incarcerated during the past year. However, the specific numbers of such patients in each clinic were not requested in the survey.

Surprisingly, half of those responding indicated that their clinics received new patients during the past year who were referred to MMT by the criminal justice system. The exact referral sources – eg, drug courts, parole systems, etc. – are unknown; still, this is an encouraging trend.

Discouraging Fates

On the other hand, the reported fates of MMT patients in jails or prisons is discouraging. Survey results found that only 17% are continued on methadone while incarcerated (see *Graph*).

Although *AT Forum* surveys are informal studies, rather than scientifically rigorous, this number coincides closely with the 15% continued on methadone reported by extensive nationwide surveys of jail/prison administrators (see references in the original *AT Forum* article).

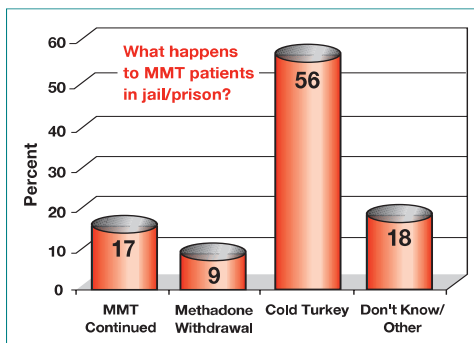
Comments from respondents indicate that methadone may be continued during short-term stays in city or county jails, but discontinued in prison. However, any provision of methadone appears to vary by location and depends on the outlooks of individual criminal justice administrators.

Forced Withdrawal

Only 9% of MMT patients are withdrawn from methadone gradually (*Graph*). However, reader comments suggest that sometimes only 1 to 3 weeks might be allowed for a withdrawal process that should take months.

Interestingly, both a clinic physician and local sheriff from the same community submitted comments independently. They concurred that for prisoners to receive methadone at least 2 deputies have to take them to the MMT clinic each day for dosing during the withdrawal process; a service for which inmates or their families might be charged.

Survey respondents noted that, in some circumstances, prisoners might be provided



clonidine or other nonopioid medications to ease the withdrawal symptoms. Although, in most cases, they believed that the withdrawal process was too rapid and the medications too ineffective to fully alleviate suffering.

Sanctioned Agony

Survey participants reported that more than half of MMT patients (56%, *Graph*) are forced to withdraw without any assistance whatsoever. That is, "cold turkey" – an agonizing process.

In some cases, it was reported that this resulted in emergency hospitalizations, including admissions to intensive care units. It is widely believed that forced opioid withdrawal is uncomfortable but not harmful, which does not take into account that some MMT patients have other physical disorders and cannot tolerate the physical stress.

Overall, the *AT Forum* survey data on the fates of MMT patients who are entangled in the criminal justice system are upsetting but not unexpected. Still, this sort of treatment of prisoners, many of whom are awaiting trial or were convicted of nonviolent crimes, is of concern. The criminal justice system apparently has a long way to go in providing prisoners with the disease of opioid addiction fair and humane treatment.

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