

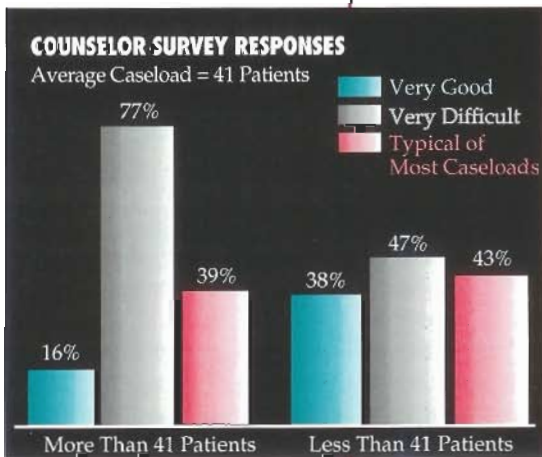
Forum

THE QUARTERLY NEWSLETTER OF ADDICTION TREATMENT FOR CLINICAL HEALTH CARE PROFESSIONALS

VOL. III, #1

Counselor Survey

Caseloads Vary Widely



MMTP counselors around the country supervise from 3 to 105 patients, with about 41 patients being average.

That's one conclusion of the clinic counselor survey introduced in the last edition of Addiction Treatment Forum. We asked how many patients counselors were assigned, and

whether they thought such a caseload was very good or very difficult. We also asked whether they thought their caseload was typical of most other MMTP clinics.

We further asked whether their clinic operated on a for-profit or a non-profit/public basis, and for information regarding geographic location.

A total of 91 response cards were returned.

As the chart on this page indicates, over three quarters of those counselors responding believe a caseload above the average of 41 patients is very difficult. Only 16% found this to be very good; one respondent felt a caseload of 75 patients was good.

A caseload less than the 41 patient average is characterized as very difficult by 47% of the counselors,

Continued on Page 3

MMTP Notes

Advisory Board Program Empowers Patients

Shortly after Sebastian Damiani became Administrator of Beth Israel Medical Center's MMTP in New York City in March, 1993, he was approached by several patients who wanted to become more involved in their treatment. This tied-in nicely with Damiani's own participative philosophy of management.



He believes employees should be actively involved in decision making practices within the program. "I think that leads to more satisfied employees and empowers them to have some control over their workplace," he says. It was a natural extension to transfer some of these same ideas into the patient realm; hence, a Patient Advisory Board was formed last June at Beth Israel to represent the 8,000 MMTP patients they serve.

Damiani meets with the Patient Advisory Board once a month to discuss issues that patients are concerned about and how positive actions can be taken. Currently, there are eight patient representatives on the Board, but they are

Continued on Page 2

IN THIS ISSUE

COUNSELOR SURVEY RESULTS	P. 1
MMTP NOTES	P. 1
FROM THE EDITOR	P. 2
PATIENT'S PERSPECTIVE	P. 2
METHADONE MYTHS	P. 3
WOMEN & ADDICTION	P. 4
CURRENT COMMENTS	P. 5
METHADONE DOSAGE SURVEY, PART II	P. 6
CASE STUDY	P. 7
FEEDBACK LETTERS	P. 8

You Asked For It...Let's Hear From MMTP Patients

We recently received the following note: "You need to talk to patients more in order to find out what's going on first hand with their treatment. There are lots of unqualified methadone clinics around the country... with inept counselors, insensitive nurses, and so on."

A.T.F. is circulated widely to MMTP patients in the U.S. and other parts of the world. Now it's your turn to present your opinions.

Our survey question for this issue of A.T.F. is:

What is the single most important change you would make at the MMTP clinic you attend?

Make a brief statement on the feedback card inserted in this issue and send it in, or write to us at: AT Forum; 1515 Woodfield Rd.; Suite 740; Schaumburg, IL 60173. Be certain to include the location of your clinic; however, no individuals' names or clinic identification information will be reported in our survey results article to appear in the next issue.

Stewart B. Leavitt, Ph.D., Editor

A.T.F.

Patient's Perspective

The following patient-authored poem was sent in by a counselor at a treatment center in Alabama:

My Face

A life of drugs is all I've ever known, from the time I was a teenager and even now that I'm grown.

When I look in the mirror, it's not my face I see, I'm not the same person that I used to be.

The drugs got a hold on me and just took control. They took everything I had, but they didn't get my soul.

I'm getting help now, trying to find a better way. It seems to be getting easier with each passing day.

Without the drugs, only a life of sobriety, I'll finally be able to fit into this society.

I'm really trying to get help and change my life around. This morning, when I looked in the mirror, it was a glimpse of my face that I found.

I know I have a long way to go, but I'm finally learning how to say no...To the drugs, to the life I'm leaving behind. Because from now on when I look in the mirror, it's my face I want to find.

A.T.F.

Continued from Page 1

actively recruiting new members. A major challenge at Beth Israel is that their 23 MMTP clinics are dispersed over a wide geographic area, and many patients from outlying areas find travelling into New York City for Tuesday evening Board meetings inconvenient.

One of the first issues raised by Board members were concerns over how methadone dose was being used by some clinics as a "motivational tool."

According to Damiani, such practices are not part of Beth Israel's philosophy: "We try not to use the methadone as a behavior modification tool and withhold medication or make medication levels contingent on patients performing specific tasks."

As a result of negative examples revealed by Board members, he wrote a major memo to the treatment staff (with co-signatures from the Chief of Medical Services and Director of Nursing) to reinforce the Center's philosophy. Damiani believes this was quite successful: "From the feedback I've been receiving, some of those issues have gone away," he says.

"Overall, I think it's the beginning of something unique...giving patients a voice in some of their treatment concerns"

A second major issue raised by patient Board members involved vocational opportunities for patients. As a result, with the assistance of some outside funding, Damiani reactivated a program to train 10 to 12 patients to become counselors. It's

possible that additional counselor training opportunities will be funded. Also, he is trying to get Beth Israel Hospital to start a more focused recruitment program offering patients appropriate employment opportunities at the Medical Center.

Another project under consideration by the Board is a videotape program to help orient new patients into treatment. It would help educate them and hopefully improve their experiences and retention in MMTP.

Today, Damiani claims, "Overall, I think it's the beginning of something that's unique and doesn't happen that often in [MMTP] programs. It's truly giving patients a voice in some of their treatment concerns."

A.T.F.

Continued from Page 1

however 38% found this to be very good. (The numbers do not add up to 100% because some response cards did not contain complete information.)

What's a typical caseload? There is closely divided opinion: 39% believe an above average caseload is typical, while 43% feel a below average caseload is common.

The only regional difference noted was that New York appears to have the highest caseloads: 64% of the above average caseloads and only 19% of the below average caseloads were in New York. No trend was evident to distinguish differences among for-profit versus non-profit/public clinics.

Numbers Only Part Of The Story

Many counselors provided comments and there was concern that caseload numbers alone might be misleading unless descriptive data is presented about the type of services provided. One respondent noted that if counseling services are not a part of treatment, then a caseload of 50-60 patients would be quite manageable. However, when individual, family, and group counseling are provided, along with vocational and medical services, a caseload of more than 20 patients becomes difficult to manage.

At some clinics, counselors must also supervise non-methadone patients as part of their caseload. Paperwork requirements also affect the number of patients that can be effectively managed.

Here Is A Sampling Of Counselor Comments:

"Counselors should be limited to 30 clients to provide proper care. In order to save a dollar, we sacrifice the client to partial treatment." — *Buffalo, NY*

"40 clients is the cut-off level if one is to provide comprehensive services. An increase in counselor-to-patient ratios would decrease services." — *San Angelo, TX*

"The required paperwork is what makes my caseload [40 patients] difficult. Otherwise, meeting the on-going and emergency needs of clients themselves would be much easier." — *San Francisco, CA*

"My caseload [40 patients] is difficult but enjoyable. My main problem in this

clinic is that our doses are so low that counseling is often devoted to those types of complaints." — *St. Louis, MO*

"The average caseload in our clinic is approximately 65 patients per counselor. In my opinion this is the most serious

problem with methadone maintenance as a modality. I know of no other modality in the drug treatment field where at least once a week counseling is not a component of treatment.

... For many of our patients we function as a dispensary until they are in trouble in one form or another (relapse, etc.)." — *Bronx, NY*

"Caseload [78 patients] too high! As 1/3 of my caseload is severely ill, I do not have sufficient time to do my job adequately. 1/5 of my time is spent collecting bottles and urine. The counseling staff is not respected professionally by our administration." —

Brooklyn, NY



A.T.F.

Methadone Myths

Methadone Hurts Your Health

There have been well over 2,000,000 patient years on methadone, and thousands of babies have been born to mothers on methadone. The health status of patients on methadone has probably been studied with greater frequency and depth than that of any other medication.

Mary Jeanne Kreek, MD, Senior Research Associate and Physician, Department of Biology of Addictive Disease, of The Rockefeller University, concluded as follows in her encyclopedic review of the literature (Kreek, 1983):

"The most important medical consequence of chronic methadone treatment, in fact, is the marked improvement in general health and nutritional status observed in patients as compared with their status at time of admission to treatment. Most medical complications observed in methadone-maintained patients are either related to ongoing pre-existing chronic disease, especially chronic liver disease, the onset of which occurred prior to entry into methadone treatment, or to coexisting new diseases or illnesses or to ongoing polydrug or alcohol abuse. Clearly the most common cause of serious medical complications in methadone-maintained patients both during and following detoxification is chronic alcohol abuse."

[The above is excerpted from "Myths About Methadone," NAMA Education Series, Number 3, March 1992. The Author is Dr. Velten, Clinical Services Director at the BAART Methadone Program, San Francisco.]

A.T.F.

Women & Addiction



Comprehensive Care Essential; Methadone But One Component

For an update on women and addiction treatment concerns, A.T. Forum spoke with Loretta P. Finnegan, M.D. She is Senior Advisor on Women's Issues, National Institute on Drug Abuse, National Institutes of Health, Rockville, Maryland.

Methadone is but one part of the overall care that is essential for opiate addicted women, Dr. Finnegan believes. "So, setting up a traditional methadone dispensing program without provisions for childcare, outreach, medical and psychosocial support services is not going to meet their needs."

According to Finnegan, there are four treatment components needed:

1. Medical assessment and accessible treatment. Also some staff should be knowledgeable about methadone and its complications. A frequent mistake is that a patient may present with a symptom that is erroneously attributed to

methadone or to illicit drug use when, in fact, the individual has a serious medical condition.

2. Psychological assessment and psychiatric treatment when necessary for either depression or for post traumatic stress syndrome. As many as 60% of women that present for treatment have a psychiatric disorder, most frequently depression. A high percentage, 80 to 90%, of women who come to treatment have been physically and/or sexually abused as children and continue to be abused as adults; frequently by their partner.

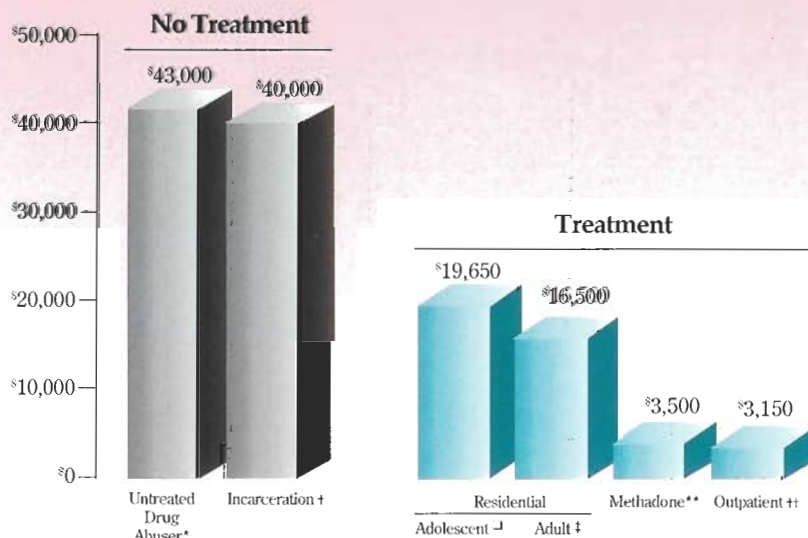
3. Sociological issues, including survival management, such as housing, clothing, food, financial issues. Drug addicted women are often impoverished. There also has to be a balanced staff to address the issues of race, social class, and culture.

4. Issues concerning parenting women: mother/infant relationships, early childhood development, child care, and educational activities for mother and child. About 85% of women in treatment are in the child bearing ages and 80% already have a child in their care. Not only does a woman who is drug addicted have to care for her children, she frequently is also responsible for family members who may have HIV disease, who may be elderly, or in some way disabled.

Staffing requirements to meet all the needs of addicted women in their child bearing years seem challenging. According to Finnegan, the disciplines involved include: a general medical practitioner, an OB/GYN specialist, a psychiatrist, a pharmacist (from the standpoint of the methadone dispensing), a nurse, counselors (not only drug abuse counselors, but also psychologists and HIV/AIDS counselors), social workers, a child development specialist, child protection workers, legal consultants, and outreach workers. That's over a dozen specialties which are extremely useful and should be part of the treatment regimen in these programs on

Continued on Page 8

COMPARE THE COSTS



All Costs Are For a 12-Month Period, Per Person

Sources:

- * New York State, Division of Substance Abuse Services, 1985. Estimated social and government costs of an untreated drug abuser.
- † C. Godsnaw, R. Koppel, and R. Pancoast, "Anti-drug Law Enforcement Efforts and Their Impact," U.S. Customs Service, Department of the Treasury, Washington, D.C., August 1987.
- ‡ William Butynski, Paper presented at Research Analysis Utilization System (Raus) Review Meeting, National Institute on Drug Abuse, Washington, D.C., August, 1989.
- †† Dan R. Gerstein and Henrik J. Harwood, eds. *Treating Drug Problems*, Vol. I, (Washington, D.C.: National Academy Press 1990) 189.

- ** Gerstein 1981.
- †† Gerstein 1989.

Georgia MMTP Coalition Supports Providers

A.T. Forum interviewed Onaje Lacey, Director of the Atlanta West Intake and Treatment Center, Atlanta, GA and Chairman of a fairly new group called the Georgia Methadone Providers Coalition (GMPC).

A.T. FORUM: What's the purpose of the GMPC?

ONAJE LACEY: The GMPC is an organization that we first started almost two years ago in May of 1992 as a providers group that would link with The American Methadone Treatment Association headed by Mark Parrino. We were encouraged by our state director Pam Redmond at the time to do so. We organized and I was selected as the first Chairman of the organization.

In general, we want to promote the methadone field as a viable, effective treatment modality. We see ourselves as an advocacy organization, and also as a mutual support organization. We intend to gather information, share it with the public, share it with one another and try to reduce the stigma associated with the modality and with addiction in general.

A.T.F.: What sort of response have you received from providers?

LACEY: Within Georgia we have had the participation and involvement of all the licensed MMTP's with almost an even split between seven public providers and eight private providers. I think we are going to see some growth in the number of Georgia programs. There have been a couple of new program applications within the last 12 months, and the approval of one program in the underserved southern portion of the state.

A.T.F.: Are you trying to influence state legislation?

LACEY: We are in the process of becoming incorporated as a non-profit corporation in the state. We want to function on several levels and having influence over legislation would certainly be a priority for us. The real challenge for us is going to be developing a consensus among public and private providers, who may in a sense have different goals and objectives, particularly as they relate to rules and regulations above and beyond what is required by the FDA and DEA.

A.T.F.: Is your state typical of what's going on in the Southeast United States?

LACEY: An important program that our current state director, Thomas Hester, M.D. is working on is a regional registry to prevent persons receiving methadone from programs in different states simultaneously.

A.T.F.: Is this being put on computer?

LACEY: They're not at that point yet. We do have a new central registry within the state which was established in 1993 and it is on computer.

Any patient being added to a methadone program must get an identification number from a central office in Atlanta. The people providing those numbers check identifying information such as social security numbers to make sure that person is not registered on another program. It's worked well and there's been complete support for it.

A.T.F.: Is there any state representation in the GMPC?

LACEY: Initially there was but it has been reconsidered. Those folks would attend by invitation.

One of the things that we're focusing on now is to what extent we are going to involve consumers [i.e., patients], because in Georgia there is a strong movement in the whole mental health and substance abuse arena to involve consumers, family members and advocates more at all levels.

We don't currently have any consumers represented in the organization. Our bylaws allow for general members to be any persons interested in the field. But the voting members are now restricted just to organizations providing these services.

A.T.F.: If there's one immediate goal that your Coalition could achieve, what would it be?

LACEY: We want people who don't know about this modality at all to become aware of it. We want people who have negative impressions to at least get information that might persuade them to look at us more objectively in terms of what we're doing, what our successes are. We're going to certainly push the fact that we can be instrumental in improving the quality of life of narcotic addicts and their families while also preventing the transmission of HIV infection.



A.T.F. Methadone Dosage Survey (Continued)

Part II: Regional & Clinic Operation Differences

In the last issue we reported on readers' responses to our survey of methadone dosage practices at MMTP clinics. To summarize: the results indicate a mean low dose of 22 mg/day; mean average dose of 57 mg/day; mean high dose of 89 mg/day.

The average and high dosages have increased since an earlier survey by D'Aunno and Vaughn ["Variations in Methadone Treatment Practices: Results From a National Study," JAMA, Jan. 8, 1992, 253-258] which found that average dose was 50 mg/d or less and the upper limit [highest] was 79 mg. However, current dosages in our study are below the 60 to 100 mg optimum range widely advocated in scientific literature and guidelines.

Our survey also asked whether the respondent's clinic operated on a for-profit or a non-profit/public basis. We asked for information regarding the location of the clinic so we could divide the responses into four regions.

Results and Observations

We found small differences in dosage levels by region [see map], with the East and South reporting higher values. Only the mean high dose of 96 mg/d in the East is statistically significant ($P < 0.05$). This is consistent with the earlier

D'Aunno and Vaughn study which reported higher limits on dose level in what they called the "Mid-Atlantic" region.

Also similar to the D'Aunno and Vaughn study, we found a difference in terms of clinic operation: for-profit clinics offer higher methadone dosages [see chart]. The mean average dose and mean low dose are significantly higher ($P < 0.05$).

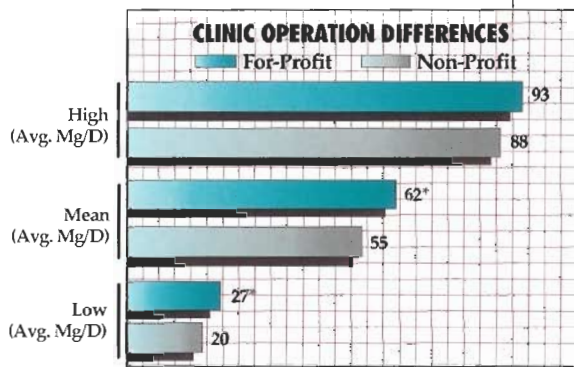
Commentary

According to our study, a patient's best chance of getting a higher dose would be at a for-profit clinic in the East. Is there something special about patients at these clinics that requires them to need higher dose levels than elsewhere? We doubt it.

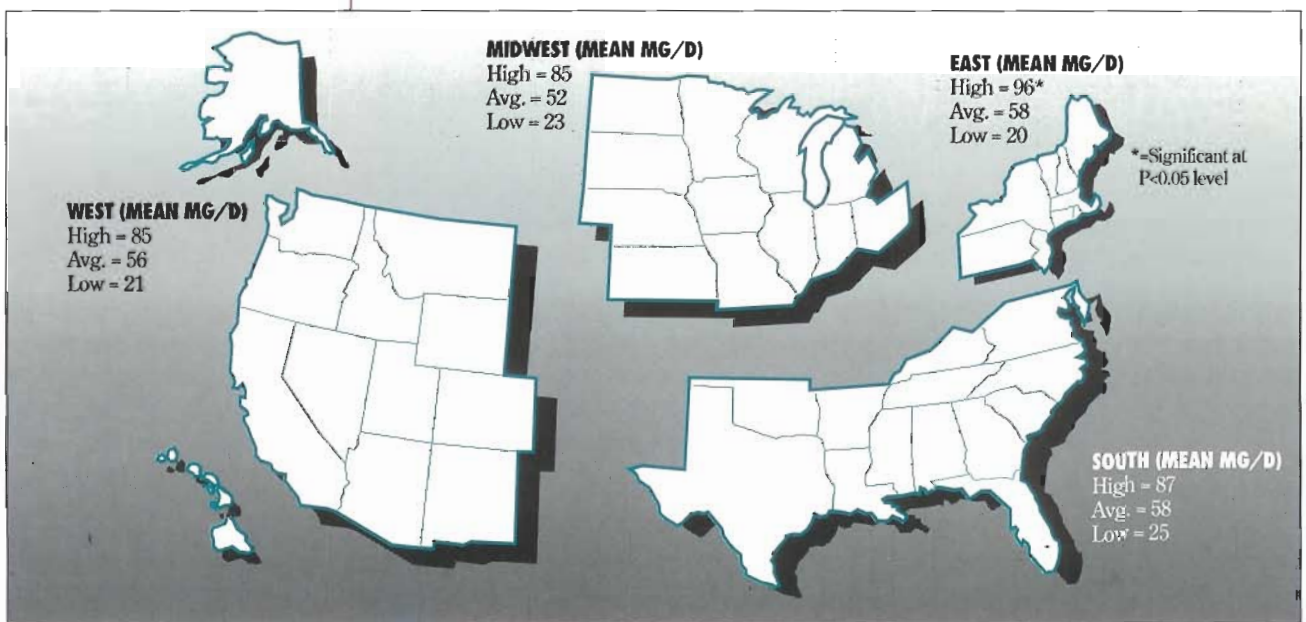
Our survey was limited in scope, yet it raises some interesting questions for further thought and investigation. The current concept of "adequate dose" seems to be variously interpreted in ways that often result in lower than optimal dose. In their more extensive study, D'Aunno and Vaughn found that, "Units with higher average dose levels had longer average lengths of time in treatment for their clients. Length of time in treatment is critical; results from several studies indicate that time in treatment is the strongest predictor of treatment success."

See page 7 for comments
by Survey Respondents

A.T.F.



*Significant at $P < 0.05$ level



Comments by Dosage Survey Respondents

Following is a sampling of comments from readers on their dosage survey response cards:

"Politics and funding drive dose levels." - *California*

"Dosage is according to addiction level and patient's symptoms of withdrawal as determined by program physician with advice from clinician." - *Connecticut*

"A program's high, low or average daily dose is meaningless. Only when applied to the specific situation that a particular patient faces can a therapeutic dose level be determined." - *Connecticut*

"I have found that patients on doses higher than 70 mg are relatively clean and tend to stay in treatment longer." - *Illinois*

"Our highest possible dose is 70 mg." - *Maryland*

"We have approximately 5-10% of clients above 100 mg daily. One is on 200 mg split dose. We believe each client is an individual and dose should be individual as well." - *Maryland*

"My dose has been 100 mg/d for the last three years, and I have been drug-free during that time." - *Patient*

"I believe 50% of rehab has to do with counseling and your therapist. But the patient must want to stop drugs and realize there may be minor discomfort initially." - *Patient*

"Some medical directors should be provided with updated information on addiction treatment. Many should have their philosophy examined." - *New York*

"The laxity in treatment guidelines practiced by private treatment programs in our area greatly undermines the value of methadone treatment and generally creates a very poor public image." - *North Carolina*

"We believe the patient should maintain the lowest possible dosage without experiencing discomfort." - *Texas*

"Dose is based on client need as determined by individual evaluation. Length of treatment is indefinite." - *Washington*

"Placing addicts on 90 mg of methadone and 'chemically warehousing' them is not the answer." - *Wyoming*

A.T.F.

"There shouldn't be a limit or restrictions...whatever your body needs should be provided to you" - Patient in Ohio

CASE STUDY

MMTP Retention Rate Drops 38% What Happened?

Spanning 18 years – from 1970 when the methadone maintenance treatment program at the Center for Health Care Services, San Antonio, Texas was first established through 1988 – the 1-year patient retention rate decreased from 74% to 36%. The Center, a multimodal substance abuse treatment program, is publicly supported and was serving 489 methadone patients at the conclusion of a study recently reported in the *Journal of Substance Abuse Treatment*.

Over the years, several key changes took place...

- In 1970, the median methadone dose was 90 mg/d; no daily dose exceeded 160 mg. By 1988, the usual daily dose was 45 mg.
- Patient fee payment requirements went from zero in 1970 to as much as \$6.00 per day in 1987, although there were reduced fee provisions for hardship cases.
- Initially, the program did not allow take-home methadone doses. By 1988, take-home was provided in accordance with FDA regulations.
- Over the years, the level of professional staff training and quality of services improved. In 1970, case-

workers had over 100 patients each; by 1988, this was reduced to about 50 patients each.

- Treatment structure also improved from a low level initially. Frequency of counseling sessions and other support services were upgraded over the years.

What made the difference?

Provision of take-home medication, increased quality and quantity of services should have improved retention. Also: "While patient characteristics changed from 1970 to 1988, [their relation] to retention in the two periods was not consistent," and were not deemed relevant to the drastic change in retention rates.

The authors' conclusions? "Increased fees and decreased methadone dose seem likely contributors to the decrease in retention. The decrease in methadone dose from 1970 [90 mg/d] to 1988 [45 mg/d] opens the possibility that some of the 1988 patients left because they were undermedicated."

(See, Maddux, J.F., et al. "Program Changes and Retention on Methadone." *Journal of Substance Abuse Treatment*, Vol. 10, pp. 585-588, 1993.)

A.T.F.

Continued from Page 4

either a full-time or part-time basis.

One might imagine the costs of such comprehensive care for addicted women to be prohibitively expensive, but Finnegan offers some cost figures collected from various sources to put the situation into perspective (see chart on page 4). During 1989-90, the yearly costs to society for an untreated drug abuser or incarceration were \$43,000 and \$40,000 respectively. In contrast, addiction treatment for an adult ranged from \$16,500 to \$3,150, with methadone treatment costing about \$3,500.

Finnegan stresses that by having people in treatment a great deal of money can be saved, and methadone treatment is especially economical. These costs

above do not specifically reflect comprehensive care for women. However, she notes, if one were to add up all the extra services for women and inflate the \$3,500 cost of methadone treatment up to \$10,000 per year, it would still be economically appealing, especially compared to the financial impact of no treatment.

Another benefit of methadone is that it is frequently the carrot, the motivational force, that draws the woman addict into the clinic. "Once they get stabilized on the methadone and realize, 'Hey I feel a lot better and I need these other things,' they keep returning. And clearly they need it all; the medication and those services," Finnegan says.

A.T.F.

Forum Feedback Letters

Methadone Success "Down Under"

"I have just seen A.T.Forum and am writing to congratulate you on the excellence of your publication. Your material is highly relevant to the development of methadone treatment services in Australia. The capacity of the methadone treatment system in my state of New South Wales has been growing by almost 15% per annum for almost a decade. Services are also becoming more attractive for drug users and more responsive to their needs."

Dr. A. Wodak, FRACP

*St. Vincent's Hospital Sydney Limited
Sydney, Australia*

"Methadone Anonymous"; Wrong!

The following excerpted/edited letter challenges the use of "Methadone Anonymous" as a name for self-help groups patterned after Narcotics Anonymous.

"Aren't all 'Anonymous' groups against the word that precedes that term? Alcoholics Anonymous is against alcohol, Gamblers Anonymous is against gambling, etc. It appears that a group called 'Methadone Anonymous' would be against methadone even though we know better."

"We also wonder why a methadone group would mimic Narcotics Anonymous, a group that stigmatizes methadone patients and refuses to recognize their recovery. We prefer the

term and philosophy of a 'Methadone 12-Step Group'."

"NAMA is very aware that 12-Step groups are needed for methadone patients since they have been locked-out of Narcotics Anonymous, and we applaud the initiatives of groups specifically for methadone patients."

*Stan Novick, President
National Alliance of
Methadone Advocates
New York City*

A.T.F.

ADDICTION TREATMENT

Forum

is published quarterly by
Noble Arnold & Associates,
1515 Woodfield Road, Suite 740
Schaumburg, IL 60173

Editor: Stewart B. Leavitt, Ph.D.

Publisher: Sue Emerson

Art Director: Julie Lester

©1994 Noble Arnold & Associates

Addiction Treatment Forum is made possible by an educational grant from Mallinckrodt Specialty Chemicals Company. All facts, figures and opinions are those of the sources cited. The publishers are not responsible for reporting errors, omissions or comments of those interviewed.

BULK RATE
U.S. POSTAGE
PAID
PERMIT NO. 125
DES PLAINES, IL
60018