

# Forum

THE QUARTERLY NEWSLETTER FOR CLINICAL HEALTH CARE PROFESSIONALS ON ADDICTION TREATMENT

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***“The frequency of urine screening should be clinically appropriate for each patient.”***

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## Clinical Concepts

### Drug Screening: How Often is Enough?

As many as 1 of every 5 patients in methadone maintenance treatment (MMT) may continue their substance abuse to some extent, which fosters noncompliance with therapy and high dropout rates.[1] Recently, the Winter 2005 edition of *AT Forum* described substance abuse monitoring via on-site urine screening as a vital therapeutic tool for helping to safeguard patients, assess their progress in treatment, and provide better care.[2]



However, an important question is: *Just how often should drug screening be done to be most effective?*

### Balancing Costs & Benefits

The answer is: Frequency of drug screening ultimately depends on the patient.

More than a decade ago CSAT recommended: “The frequency of urine screening should be clinically appropriate for each patient and allow for a concerned and rapid response to the possibility of relapse.”[3] More recently, Goldstein and Brown observed that a *practical screening schedule* will signal needs for additional counseling and/or increased methadone dose for individual patients.[4] By “practical” they mean a frequency that is a reasonable compromise in terms of costs – expense and effort – versus benefits.

In that regard, daily screening would be maximally effective but it is totally

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## Practice Pointers

### AD/HD: A Common Problem During MMT?

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*Director of Development for Clinical Services at Discovery House, Home Office, Providence, RI*

Attention-Deficit/Hyperactivity Disorder (AD/HD), although somewhat controversial, is a real mental affliction and may be more common during methadone maintenance treatment (MMT) than many believe.[1] Nearly 1 in 5 MMT patients may be affected by AD/HD to some extent; yet, many persons working in the field do not fully understand this disorder.

For starters, take this quick quiz. Answers may be found within this article and at the end.

### AD/HD Quiz

#### True or False...

1. Patients with AD/HD show a persistent pattern of inattention and/or hyperactivity-impulsivity.
2. These patients may not demonstrate AD/HD behaviors in all settings or at all times.
3. Symptoms and severity can range from mild to severe.
4. AD/HD is more common in males.
5. Stimulant medications can be effectively used in MMT patients with AD/HD.
6. Living with AD/HD also requires changes in coping strategies.

### Understanding Prevalence

Up to 8% of boys and 5% of girls under age 18 have AD/HD. Girls tend to be under-identified and are often considered “day dreamers,” disorganized, and careless, which is typical of attention deficit disorder (ADD).

As many as half of children and adolescents with AD/HD continue having symptoms into their adult lives, which

*Continued on page 4*

## Events to Note

For additional postings & information, see:  
[www.atforum.com](http://www.atforum.com)

### October 2005

#### American Psychiatric Association 57th Institute

October 5-9, 2005  
San Diego, California  
Contact: 703-907-7300; <http://www.psych.org>

#### American Academy of Child & Adolescent Psychiatry 52nd Annual Meeting

October 18-23, 2005  
Toronto, Ontario; Canada  
Contact: 202-966-7300; <http://www.aacap.org>

#### ASAM State of the Art in Addiction Medicine

October 27-29, 2005  
Washington, DC  
Contact: 301-656-3920; <http://www.asam.org>

### November 2005

#### American Public Health Association 133rd Annual Meeting

November 5-9, 2005  
New Orleans, Louisiana  
Contact: 202-777-APHA;  
<http://www.apha.org/meetings/>

#### Society for Neuroscience 35th Ann. Meeting

November 12-16, 2005  
Washington, DC  
Contact: 202-462-6688; <http://www.sfn.org/>

#### Association for Advancement of Behavior Therapy 39th Annual Convention

November 17-20, 2005  
Washington, DC  
Contact: 212-647-1890; <http://www.aabt.org/>

#### SECAD 2005 – International Conference for Alcohol & Drug Addiction Professionals

November 30 – December 3, 2005  
Atlanta, Georgia  
Contact: 866-293-5510;  
<http://www.naatp.org/secad>

### UPCOMING 2006...

#### AATOD (American Association for the Treatment of Opioid Dependence) National Conference

April 22-26, 2006  
Atlanta, Georgia  
Contact: 856-423-3091; <http://www.aatod.org>

#### ASAM 37th Annual Medical-Scientific Conference

May 4-7, 2006  
San Diego, California  
Contact: 301-656-3920; <http://www.asam.org>

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

## Straight Talk... from the Editor

### AT Forum "News & Updates" Reach 100

Many readers are unaware that in 1996 we began publishing at our website a regular "News & Updates" feature. Every 1 to 2 months, we produce and post brief summaries of news stories, research reports, and other items of interest that come from our continuous scan of news and literature in the addiction field.

To date, 100 monthly or bimonthly News & Updates installments have been posted, spanning July 1996 through July-August 2005 and containing more than 2,000 entries. These serve as a vital history of happenings and developments during the past 9 years in the addiction field, with a special emphasis on methadone maintenance treatment (MMT).

### Many Changes Reported

In 1996 we reported that LAAM (a longer-acting methadone requiring less frequent dosing) was being more widely adopted. Later, in 2003, we reported the discontinuation of LAAM due to concerns about adverse cardiac effects.

In 2001 we reported in News & Updates the release of revised federal regulations to improve the quality and oversight of treatment programs using methadone to treat opioid addiction. This was a major development in the MMT field, affecting many aspects of program operations and patient care. Then, in 2002, we reported the approval of buprenorphine for treating opioid addiction.

### Yet, Much Stays the Same

In 1996 we reported in News & Updates an upsurge in higher-purity, lower-cost, heroin attracting new users, including suburban youth. That trend continues much the same today, along with the addition through the years of various opioid painkillers to the growing list of abused substances.

NIMBY ("Not in My Backyard") controversies surrounding the opening of methadone clinics were just as prominent in the news during the 1990s as they are today (see *Sidebar* in this edition). In July 1996, rapid opioid detoxification under anesthesia was being promoted as a "quick, painless way to kick heroin." Today, similar claims are made in the news, although little in the way of bona fide clinical research has appeared.

### Sign-up for Current Alerts; Access Archives

You can receive via e-mail a current listing of News & Updates items when

they are posted. To register for this, click on the "Guestbook" button at the [www.atforum.com](http://www.atforum.com) website home page, fill in the information, and check the box saying, "Notify me via e-mail when this website is updated." (Your e-mail address and other information are never shared outside of AT Forum).

To examine past items, all News & Updates have been assembled into archive "Web Volumes (WEBVOLs)," each containing 10 monthly or bimonthly installments. These are under the "Addiction Resources" tab at the website and can be downloaded in Microsoft Word® format. Items of interest can be located by using the search engine at the website (top right corner) and/or the "find" function in the MS Word document (press Ctrl + F).

For example, and a bit of amusement, enter the key words "Topsy Bees" in the website search engine. Or, go directly to News & Updates WEBVOL\_5.doc, press Ctrl + F, and enter the 2 words.

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### NEW SURVEY: What is Addiction Recovery?

Please respond to the following survey questions:

1. Does "recovery" mean being free of the disease of addiction?  Yes;  Not sure;  No
2. Is a person in true recovery 100% abstinent from illicit drugs and alcohol?  Yes;  Not sure;  No
3. Can a person "in recovery" be taking methadone?  Yes;  Not sure;  No
4. Is a renewed sense of spirituality essential for recovery?  Yes;  Not sure;  No
5. Are you responding as a  Patient,  MMT clinic staff member, or  Other?

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 web site to respond online. As always, your written comments are important.

### Speaking Up for Recovery

As this edition of AT Forum goes to press, National Alcohol & Drug Addiction Recovery Month, September 2005, is underway. This initiative, founded by SAMHSA (U.S. Substance Abuse and Mental Health Services Administration) 16 years ago, aims to promote the benefits to society of treatment for addiction. It further recognizes the contributions of treatment providers and promotes the message that recovery from addiction is possible.

This September's theme is "Join the Voices for Recovery," which dovetails nicely with another group, called the Faces & Voices of Recovery. This is a grassroots organization of advocates, including people in recovery from alcohol and other drug addiction, their family members, friends, and allies. Their mission by speaking out is to make a difference in public understanding of addiction and recovery, and to change policies that raise barriers to addiction recovery.



However, one challenge seems to be that "recovery," like "love," is something everyone believes they intuitively understand; yet, it has never been adequately described. The Center for Substance Abuse Treatment (CSAT) appears to have recognized this dilemma and scheduled a "National Summit on Recovery" for late September 2005 to address the issue. They hope to identify the core principles of recovery, measures and markers of recovery, and elements of recovery-oriented care.

This topic also will be addressed in upcoming editions of AT Forum. For starters, please respond to the survey on "What is Addiction Recovery?" in this edition, using the attached feedback card or at our website ([www.ATForum.com](http://www.ATForum.com)).

For more information on what happened during Recovery Month 2005, visit: <http://www.recoverymonth.gov/> and/or <http://www.facesandvoicesofrecovery.org> (and sign up for their eNewsletter).

### NIMBY: Remarkable Controversy, Still Going Strong

Almost since its beginning in the mid-1960s, methadone maintenance treatment (MMT) has been plagued by NIMBY; mostly, due to the stigma, prejudice, and misunderstanding surrounding this very effective therapy for opioid addiction. An acronym for "Not In My Backyard," NIMBY universally applies to resisting any unwanted development – e.g., prisons, chemical plants, landfills – from entering a community.

Everyone it seems wants their community roads lined with parks, trees, quaint schoolhouses, and upscale boutiques. In contrast, opponents of MMT clinics have characterized them in press reports as dingy eyesores that serve loitering "junkies" with needles hanging out of their arms as drug pushers prowl nearby. In reality, the clinics serve those opponents' neighbors, family, and friends who may develop opioid dependencies for numerous reasons.

As one Homeowner Association president put it: "We're all in favor of [methadone] treatment programs, but not in this neighborhood" (*Bristol Herald Courier* [VA], 12/13/03). Or, as a police chief stated: "It's like a nuclear power plant. People need it, but they don't want it in their back yard" (*Portsmouth Herald* [NH], 5/7/05). Messages like those have been repeated in various ways time and again through the years, and in communities throughout America.

Where should MMT clinics be located? The answers often include, "...away from our schools, away from our children and parks... and residential and business areas" (*Roanoke Tribune* [VA], 2/26/04). Sometimes, local hospitals have been suggested as logical outposts for MMT clinics; however, due to persistent stigma and prejudice, hospitals rarely want anything to do with methadone treatment for addiction.

One solution has been putting MMT on wheels via methadone-dispensing vans, as in Vermont (see, *AT Forum*, Summer 2004). Even then, many months passed as one community after another debated suitable sites where the van could stop briefly each day to serve patients (*Times Argus* [VT], 3/29/05, 6/17/05).

Increasing numbers of methadone-associated deaths in recent years have inflamed community fears. Yet, according to all reports, including a federal government investigation, MMT clinics are not the source of "killer methadone," as news media have described it (see, *AT Forum*, Spring 2004). And, contrary to protests by community activists, police authorities have often insisted there is virtually no increase in vehicle traffic or crime associated with local MMT clinics (*Washington County News* [VA], 12/25/03).



Citizens protest an MMT clinic in Maine.  
Photo, R. O'Malley, *Courier-Gazette*, 12/7/04

Good news about MMT often goes unreported. An exception was the headline, "Feared problems fail to materialize at clinic" (*The Herald* [VA], 1/31/05). Following a 7-year battle to open an MMT program in Everett, Washington, nearby residents, police, and city leaders reported the clinic had been a "good neighbor" without any signs of problems. This sort of success is much more common than many realize or the press reports.

Yet, as one editorialist observed, the fact that MMT is still surrounded by debate and controversy after nearly 40 years is remarkable (*Bangor Daily News* [ME], 11/27/04). No matter where a clinic is proposed, opposing arguments generally founded on ignorance have continued much the same through the years. The unasked and unanswered question is: Why doesn't the public know the truth about MMT and its demonstrated benefits to individuals and their communities?

*AT Forum* has prepared an 8-page report titled, "A Community-Centered Solution for Opioid Addiction: Methadone Maintenance Treatment (MMT)." This document provides an evidence-based and balanced perspective on the treatment of opioid addiction with methadone that can be used to educate community groups. It is available for download free of charge at: [http://www.atforum.com/SiteRoot/pages/addiction\\_resources/com\\_ctrd\\_mmt.pdf](http://www.atforum.com/SiteRoot/pages/addiction_resources/com_ctrd_mmt.pdf).

affects relationships, school, work, and adult functioning. And, an estimated 50% of adolescents and adults who have AD/HD develop some substance use disorder.

Studies suggest that 5% to 25% of all persons entering substance abuse treatment have AD/HD.[2] Carlson [3] and King et al. [4] have estimated that approximately 19% of MMT patients have symptoms of AD/HD.

**What is AD/HD?**

In defining AD/HD, the DSM-IV identifies two clusters of symptoms: inattention and hyperactivity-impulsivity.[5] Some of these are summarized in the Table.[1]

In order to diagnose a person with AD/HD, the individual must exhibit a cluster of persistent symptoms that are not accounted for by another diagnosis and are present in two or more settings – such as school, work, and/or social situations. The intensity of the symptoms can range from mild to severe with varying severity in different settings and at different times[5]; a firm diagnosis is best made by a healthcare practitioner with special training.

**Recovery Implications**

AD/HD symptoms of impulsivity or inattention may interfere with a patient’s ability to sit through a counseling session or self-help meeting. The symptoms also may interfere with the ability to retain and use important information in day-to-day recovery.

Patients with AD/HD often report that these symptoms were present before the onset of drug use. They may have used drugs to feel more comfortable and may exhibit more severe AD/HD symptoms throughout recovery; although, the symptoms also may appear different at various stages. In early recovery many patients with AD/HD report difficulties resisting urges to use illicit substances (impulsivity), difficulty concentrating (inattention), and restlessness (hyperactivity).

Assisting the patient with AD/HD to learn relapse prevention and coping skills may take longer and need smaller steps. Impulsivity impacts on the MMT patient’s ability to think before acting; capacity to plan choices and responses before an event; and ability to act on planned choices. One 20 year-old heroin-abusing patient stated: “I don’t know what I am going to do until after I’ve done it.”

| AD/HD Symptom Clusters  |   |
|---|---|
| Inattention   | Hyperactivity-Impulsivity   |
| <ul style="list-style-type: none"> <li>• Careless mistakes, failure to attend to detail</li> <li>• Difficulty sustaining attention</li> <li>• Does not listen</li> <li>• Poor follow through, failure to finish</li> <li>• Difficulty organizing tasks, activities</li> <li>• Avoidance of effort-demanding tasks</li> <li>• Losing things</li> <li>• Easily distracted</li> <li>• Forgetful in daily activities</li> </ul> | <ul style="list-style-type: none"> <li>• Fidgets, squirms</li> <li>• Unable to remain calmly seated</li> <li>• Restlessness</li> <li>• Inability to relax quietly</li> <li>• Always “on the go”</li> <li>• Talks excessively</li> <li>• Blurts out answers</li> <li>• Can’t wait for turn</li> <li>• Interrupts, intrudes.</li> </ul> |
| Source: CSAT TIP 42 [1]   |   |

**Counselor’s Role**

The counselor can perform a vital role in helping MMT patients with AD/HD.[6]

First, the counselor needs a good understanding of the symptoms and an optimistic outlook regarding the patient’s potential for recovery. Many patients with AD/HD have acquired negative attitudes about their abilities to succeed at anything, let alone recovery, so the MMT counselor can help the patient achieve small successes that contribute to a sober lifestyle. Larger goals that create frustration become risks rather than motivators.

Second, the counselor can help the patient find a competent psychiatrist or other appropriate clinician who can assess and diagnose the patient’s condition and make further treatment recommendations. MMT patients who “know something is wrong” find encouragement in having a diagnosis and a plan for treatment.

Third, the MMT counselor can help the patient with AD/HD learn recovery and coping skills that support a sober lifestyle. These patients need to learn how to recognize dangerous people, places, and things that can hinder achieving or sustaining abstinence.

Fourth, counselors can help these patients evaluate if and when self-help meetings are appropriate. For AD/HD patients in early recovery and/or with severe symptoms, attending self-help meetings may be more frustrating than useful.

Fifth, the MTT counselor can teach patients a variety of specific life-skills that are useful for both recovery and AD/HD symptom management. Compensatory skills such as making “to do” lists, creating schedules, or establishing a routine help patients with AD/HD stay on task, finish activities, and develop structure in everyday life.

**Medications Can Help**

Many MMT counselors and their patients are concerned about the use of

psychotropic medications, questioning if a person taking them has “real recovery” or “real abstinence.” However, patients with AD/HD on appropriate medication are more likely to achieve stable, sober, and productive lifestyles.

One concern is that certain AD/HD medications, such as methylphenidate or dextroamphetamine, have abuse/addiction potential. Studies have shown that adult patients with AD/HD are not likely to misuse, abuse, or

become addicted to the stimulant medications and are more likely to be successful in substance abuse treatment.[7]

Another issue is that certain stimulant medications test positive for amphetamines in routine drug tests, requiring the patient to inform the clinic of the prescription. There also can be an interaction between methadone and other medications, including some of the mood stabilizers that might be used for severe AD/HD symptoms accompanied by a mood disorder.[7] The decision on whether or not to use additional medications rests with the MMT patient and the prescribing physician.

1. Center for Substance Abuse Treatment (CSAT). Substance Abuse Treatment for Persons with Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42. Rockville, MD: SAMHSA; 2005. DHHS Publication No. (SMA) 05-3992.
2. Biederman J, Wilens T, Mick E, Milberger S, Spencer TJ, Faraone SV. Psychoactive substance use disorders in adults with attention-deficit hyperactivity disorder: Effects of ADHD and psychiatric co-morbidity. *American Journal of Psychiatry*. 1995;152 (11):1652-1657.
3. Carlson GA. Role of attention deficit/hyperactivity disorder in methadone treatment outcome. Poster presentation: American Association for the Treatment of Opioid Dependence; Orlando, FL; October 2004.
4. King VL, Brooner RK, Kidorf MS, Stoller KB, Mirsky AF. Attention deficit hyperactivity disorder and treatment outcome in opioid abusers entering treatment. *Journal of Nervous and Mental Disease*. 1999;187 (8):487-495.
5. Diagnostic and Statistical Manual – IV – Text Revision. Washington, DC: American Psychiatric Association; 2000.
6. Levin FR, Evans SM, Kleber HD. Practical guidelines for treatment of substance abusers with adult attention-deficit hyperactivity disorder. *Psychiatric Services*. 1999;50(8):1001-1003.
7. Bhandry AN, Fernandez F, Gregory RJ, Tucker P, Masand P. Pharmacotherapy in adults with ADHD. *Psychiatric Annals*. 1997;27(8):545-555.

**Answers to “AD/HD Quiz”: All statements are TRUE.**

For useful information via the Internet, for both patients and professionals, see: CHADD (*Children and Adults with Attention-Deficit/Hyperactivity Disorder*) at <http://www.chadd.org/> and, in particular, the *National Resource Center on AD/HD* at <http://www.help4adhd.org/>.

## Interview: Treating AD/HD During MMT

To further explore the clinical implications of AD/HD during MMT, AT Forum spoke with Greg Carlson (Director, Addiction Medicine) and Manasi Kolpe, MD (Psychiatry Resident who is completing a clinical research elective in substance abuse and AD/HD) at Hennepin County Medical Center, Minneapolis.



**AT Forum:** How should an MMT patient with AD/HD be diagnosed with the disorder?

**Manasi Kolpe, MD:** The patient should first be abstinent from substance abuse for at least 1 month to be certain there is no interference from effects of drugs or alcohol, which might produce symptoms mistaken for those of AD/HD. We, as psychiatrists, use a standard structured interview with the patient and also family members, since the onset of AD/HD is during childhood and family may verify when symptoms first appeared.

**Greg Carlson:** MMT clinic staff should be more concerned about initial screening for possible AD/HD symptoms, rather than diagnosis, and these symptoms may show up early during treatment. One useful screening tool is the ASRS checklist (see below\*). Patients scoring high on such assessments can then be referred to specialists for further evaluation.

**ATF:** Should there be special therapy programs in MMT clinics for patients diagnosed with AD/HD?

**CARLSON:** Not necessarily a separate program; although, their AD/HD condition does need to be taken into account, and they may need special help in coping with the symptoms. For example, these patients have difficulties planning and keeping track of future activities, events, and appointments. So, helping them to develop a scheduling calendar, make “to do” lists, or other approaches can provide the structure that they need.

**KOLPE:** These patients can be successful in MMT, but in order to lead independent functional lives, which goes beyond mere illicit-drug abstinence, the added structure can be important.

**ATF:** What medications for AD/HD can be appropriately used in MMT patients?

**KOLPE:** Once the diagnosis of AD/HD is confirmed, and the patient is receiving adequate treatment for drug addiction, our typical first line of treatment is non-stimulant medications. For example, there have been good results in providing symptom relief with bupropion [e.g., Wellbutrin®], venlafaxine [e.g., Effexor®], and the older tricyclic antidepressants. A newer non-stimulant medication is atomoxetine [e.g., Strattera®].

If these agents don't work successfully, then we can prescribe the stimulant medications, such as methylphenidate [e.g., Ritalin®] or the dextroamphetamine/amphetamine combinations [e.g., Adderall®], provided we know the patient is complying with addiction treatment and is abstinent from illicit drugs.

**ATF:** Are there concerns with using stimulant medications in former opioid addicts?

**KOLPE:** There have been concerns regarding the potential abuse of these medications and questions about whether they should be used in patients with a history of addiction. So far, however, there have been no data showing that these persons abuse the stimulant medications.

Still, we need to be cautious, because these medications can be abused and create dependency. The concern is that the stimulants are alleged to produce cocaine-like effects, but this would not normally occur.

**CARLSON:** We've had about a dozen patients on methylphenidate during the past few years and haven't experienced any problems when they are administered the medication with their methadone at the clinic. If the stimulant drug is provided for self-administration at home, there could be greater concerns.

**ATF:** Is it necessary to adjust the methadone dose when co-administering medications for AD/HD?

**KOLPE:** We haven't found a need to adjust the methadone dose in these patients. However, tricyclic antidepressants should be used cautiously, since there may be increased toxicity of these agents in combination with methadone. Also, methylphenidate can inhibit an enzyme involved in methadone metabolism, which might increase methadone effects slightly in some patients.

**ATF:** Who should be prescribing medications for AD/HD?

**KOLPE:** Initially, the physician confirming the AD/HD diagnosis, most likely a psychiatrist, would prescribe appropriate medication. Following that, medical staff at the clinic may be in a position to adjust or change the medication, but they should maintain a consulting relationship with the original prescriber.

**ATF:** Do MMT patients on AD/HD medications need any special medical monitoring?

**KOLPE:** With venlafaxine, we monitor blood pressure more closely, and when prescribing bupropion we inquire about any seizure disorder. These are standard precautions for these medications.

Regarding stimulant medications, we screen for cardiac health and monitor the patient more closely if there is a history of heart problems.

**CARLSON:** Also, there's a perception that patients taking methylphenidate will test positive for amphetamines on drug screens, but this is not the case.

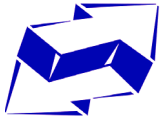
**ATF:** When can medications for AD/HD be discontinued?

**KOLPE:** This depends on how successful the medication has been for the individual patient. If the medication has helped him/her in everyday functioning and leading a more productive life, then the therapy should be continued. Adult AD/HD is a life-long illness; it doesn't go away.

With stimulant medications, we advise patients that they can discontinue the therapy on weekends or during vacations, when any reappearance of symptoms would not be as disruptive. This sort of “drug holiday” can be beneficial in minimizing potential side effects.

\*A short (6 question) and long (18 question) version of the AD/HD ASRS (Adult Self-Report Scale) screening questionnaire may be downloaded at: <http://www.med.nyu.edu/psych/psychiatrist/adhd.html>. Access verified 7/12/05.

[Drug brand names are registered trade marks of their respective manufacturers. Additional brands may be available.]



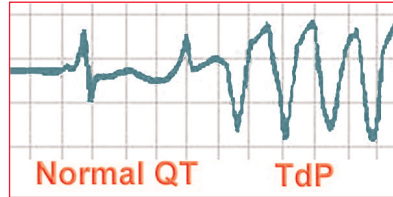
# Feedback Q&A

Questions submitted by AT Forum readers; answers from the editor.

## Does Methadone Harm Heart Health?

**Q:** There have been ongoing reports in the research literature about methadone potentially affecting heart rhythm – is this a serious problem during MMT?

**A:** During just this past year there have indeed been continuing reports of some, but certainly not all, patients prescribed methadone experiencing a longer than normal QT interval. This is a segment of the electrocardiogram (ECG) waveform that depicts the timing of heart rhythm. In some persons, if the QT interval becomes excessively prolonged, the heart may go into spasms (fibrillation) leading to a life-threatening condition called torsade de pointes (TdP).



Researchers have reported relatively small but statistically significant QT interval increases among MMT patients, although the QT measurements generally remained within acceptable limits.[1,2] Often, these heart rhythm changes were in patients taking medications or drugs in addition to methadone, or having cardiac risk factors that might normally be of concern.[3]

In some cases, QT prolongation was associated with increasing serum methadone level (SML) concentrations,[1] and/or higher methadone doses,[4] but in other studies it was not.[2,3] The reported heart-rhythm disturbances occurred over a very wide range of methadone doses; 10 to 600 mg/day.[2,5] Therefore, whether or not higher methadone doses might affect heart rhythm and to what extent are still undetermined.

In the largest investigation to date, researchers examined all adverse events associated with methadone reported to the FDA during a 33 year period.[6] Of 5,503 incidents, only 16 noted QT prolongation and 43 indicated TdP. Most cases involved methadone used in pain management – at doses ranging from 29 to 1,680 mg/day – and it could not be determined that methadone was a direct cause. Five cases (0.09%) were fatal; however, 3 of those involved factors known to influence arrhythmia.

The conclusions and recommendations coming from studies to date [1-5] consistently agree with the following authors: “Methadone treatment programs are generally considered to be a life-saving intervention for many patients addicted to heroin. The risk of TdP is likely to be small and should not deter caregivers or patients from methadone treatment. We believe it is premature to suggest routine requirements for ECGs before or during methadone treatment. However, it would be advisable for caregivers to take a careful medical history screening for known risk factors for TdP (history of syncope, family history of sudden death, electrolyte imbalance, bradycardia). It would be prudent not to co-prescribe methadone with other drugs known to prolong the QT interval because of the potential for additive effects.”[7]

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## Pain During MMT: Is Special Care Required?

**Q:** Many of our methadone-maintained patients complain of pain. Is this common and what should we do?

**A:** Clinical studies have found that up to 80% of MMT patients experience pain in a typical week, with more than half having long-lasting, chronic, pain.[1,2] Furthermore, those with chronic pain required significantly higher daily methadone doses, compared with MMT patients not experiencing such pain, although methadone itself offered no relief as a painkiller.[1]



Chronic pain in MMT patients has been linked to continued illicit drug use, psychological problems, and social isolation. In many cases, patients complain that MMT clinic staff express a lack of concern, do not listen to them, and/or do not effectively treat their pain.[2,3] Researchers suggest that treatment approaches should emphasize emotional support, taking into account the psychosocial effects of pain.[3]

Furthermore, sleep problems are common during MMT and one study found this often was associated with pain.[4] The authors stressed that there is a need during MMT to provide proper treatments for sleep disorders, as well as pain, for many patients.

Other suggestions, as previously noted in *AT Forum*,[5] are still recommended:

- MMT patients need appropriate analgesia just like any other persons with acute or chronic pain.
- However, MMT patients may need painkillers (including opioids) more frequently and in larger doses.
- The regular methadone-maintenance dose should be continued; prior detoxification from methadone is counterproductive and can negatively affect the health of the patient.
- Blockade effects of adequate methadone-maintenance dosing protect MMT patients from euphoric effects, drug craving, and/or respiratory depression associated with large doses of analgesics.
- Patients’ fears of relapse into prior substance abuse should be acknowledged and appropriate supervision, follow-up, and relapse-prevention support provided.

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**Drug Screening from page 1**

impractical. And, if drug use is daily, screening can be done at any time desired no matter how infrequently with a certainty of detecting any unauthorized substance use; so, screening every day would be wasteful.

In many cases, however, substance abuse is sporadic. Therefore, Goldstein and Brown stress that urine specimen collection can be less frequent if it is completely unpredictable – that is, random.[4] Unfortunately, randomization fails when only a limited number of screens will be performed during a given time period, such as the 8 per year minimum required by federal regulations governing MMT or even the 12 per year that seem to have become a standard in many programs. [1, also see *Survey Results*, below]

Clever patients may be able to figure out the “random” pattern, and for those intent on abusing drugs without being detected the screening becomes an “intelligence test” rather than a drug test.[5] For this and other reasons various authors have proposed that, with few exceptions, 8 or 12 screens per year are clearly inadequate for assessing if a

patient is abusing or even using illicit drugs or alcohol.[1,2,6]

**Matching Screening to Recovery**

It has been suggested that the frequency of drug screening should relate to the patient’s stage in MMT and recovery.[4,7,8] However, it is necessary to distinguish between phases of methadone pharmacotherapy versus psychosocial progress during addiction recovery (see *Table*).

| Models of Progress During MMT & Addiction Recovery   |  |  |
|--|--|--|
| Phases of MMT  | Phases of Treatment  | Stages of Change   |
| <ul style="list-style-type: none"> <li>• Initial Induction</li> <li>• Early Induction</li> <li>• Late Induction/ Stabilization</li> <li>• Maintenance</li> </ul> <small>Leavitt 2003 [9]</small> | <ul style="list-style-type: none"> <li>▪ Stabilization</li> <li>▪ Commitment</li> <li>▪ Rehabilitation</li> <li>▪ Ongoing/Maintenance, or Tapering/Reinforcement</li> </ul> <small>Moolchan &amp; Hoffman 1994 [7]</small> | <ul style="list-style-type: none"> <li>◆ Precontemplation</li> <li>◆ Contemplation</li> <li>◆ Preparation</li> <li>◆ Action</li> <li>◆ Maintenance</li> </ul> <small>Hagman 1997 [8]</small> |

“Phases of MMT” (*left side of Table*) is concerned with starting methadone and reaching a pharmacologically stable state.[9] During the methadone induction phase, lasting several weeks or much longer as the dose is increased, some authors have suggested that patients will almost always continue abusing opioids and drug screening could be pointless.[4] However, there are important safety concerns, since opioids and other drugs may interact with methadone, altering its effects and/or influencing drug overdose.[1]

Therefore, it would make sense that this is a time for high intensity drug screening, rather than less frequently or not at all.

Once the pharmacologic maintenance phase has been reached, if the methadone dose is adequate, patients should be able to abstain from opioid abuse. However, other substance abuse might continue and routine drug screening could be important for some time.

A “Phases of Treatment” model (*middle of Table*) describes clinical progression in MMT leading to either long-term participation in the program (maintenance) or eventual tapering from methadone.[7] During the stabilization, commitment, and rehabilitation phases – which may take a year or more – the patient can qualify for increasing amounts of take-home methadone.

The “Stages of Change” model (*right side of Table*),[8] based on pioneering work by Prochaska and DiClemente, acknowledges that patients often come into MMT without a commitment to addiction recovery. And, those seeking to cease opioid abuse might not be ready to abstain from other substances, such as cocaine, alcohol, or marijuana.

*Continued on page 8*

**AT Forum Survey Results: Drug Monitoring**

Readers of the Winter 2005 edition of *AT Forum* (Vol. 14, #1) were asked to respond to a survey regarding drug monitoring practices at their methadone maintenance treatment (MMT) clinics. In all there were 310 responses online at the *AT Forum* website or via response card (most, two-thirds, were clinic staff).

**Monthly Screening Customary**

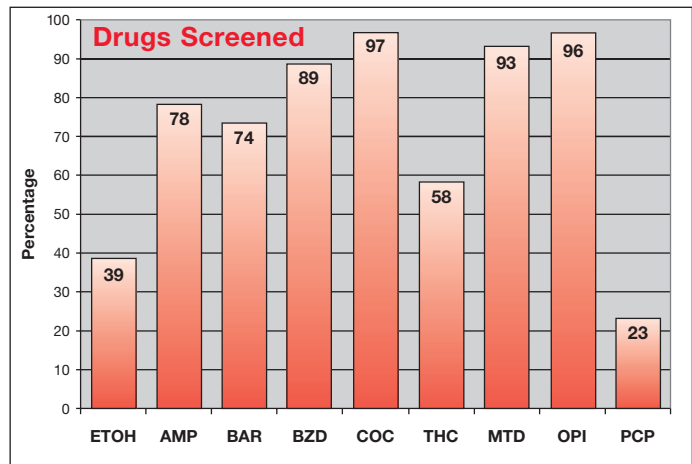
Approximately, 2 out of 3 clinics require a minimum of 12 drug screens per year for each patient, while 16% only require the minimum 8 mandated by federal regulations. A small proportion, 17%, require weekly or biweekly screening.

However, these are averages and some patients in a particular clinic may have more screenings than others. Curiously, 19 respondents claimed they typically perform less than 8 screens/year, which were not included in the averages since this was in violation of the federal minimum 8/year.

**Drugs Commonly Assessed**

As might be expected, the substances almost always assessed include: cocaine (COC), opioids (OPI), and methadone (MTD, see *Graph*). Benzodiazepines (BZD) are somewhat commonly assessed, as are amphetamines (AMP) and barbiturates (BAR). Alcohol (ETOH), marijuana (THC), and phencyclidine (PCP) are much less frequently screened.

A very small number of respondents wrote in that they specifically screen for EDDP (methadone metabolite), tricyclic antidepressants, MDMA (Ecstasy), and oxycodone and propoxyphene (which are not assessed in the usual opioid



screen). Surprisingly, screening for methamphetamines was not mentioned as a write-in choice by anyone.

**On-Site Screens Underused**

Two-thirds of respondents said urine is always the screening specimen of choice. Oral fluid screening is used by 11%, and 22% indicated that both urine and oral fluid are used at their MMT clinics.

On-site screening (not requiring shipping specimens to a laboratory) is still underused. Only 14% indicated that on-site screens are used “often,” 33% indicated “sometimes,” and more than half (53%) said such methods are “never” used.

**Drug Screening from page 7**

In this model, drug screening serves a number of therapeutic functions, from helping patients to overcome their initial precontemplation-stage denial to eventually demonstrating sustained periods of drug abstinence. However, even motivated patients actively pursuing change may experience drug lapses or relapses, which are inherent features of the disease of addiction.[8] Counselors should be trained to identify signs of impending problems.

**Minimum Screening Approach**

The models described earlier propose minimally "intensive" drug screening at weekly or every other week (biweekly) intervals during early phases or stages.[7,8] Later, when maintenance levels are attained, screening can be monthly, with a return to a weekly schedule following any drug-positive screen.

However, *a greater frequency would be more appropriate in many cases.* Almost all substances of abuse, except alcohol, may be detected in urine for about 3 days. Therefore, unless drug use is daily or nearly so, urine screening less often than every few days will potentially fail to discover substance abuse much of the time.

If patients have take-home methadone privileges and visit the clinic less often, Goldstein and Brown asserted that, "...testing is probably useless except for those who are using daily and cannot stop or who – for whatever reason – wish to be detected." [4] Thus, once patients have moved forward in their recovery to maintenance stages, drug screening functions primarily to detect full-blown relapse. And, in these cases, it would seem that screening merely confirms what already has been determined via discussions with the patient and clinical observations by astute MMT staff.[1]

Goldstein and Brown also raised concerns about patients attempting to falsify drug-screen results. "A negative test is not valid unless it is certain that the patient did not cheat, and there are many ways of cheating," they wrote.[4] It might be further suggested that MMT programs conveying unacceptably negative attitudes toward drug screening or using results for punitive purposes must always be concerned about patients trying to "beat the test" in some way.[2]

**Flexibility is Essential**

Drug screens are available using other specimens – such as, oral fluid, blood, hair, and sweat – having drug-detection periods ranging from hours to months.[1,5] In theory, these would facilitate screening at

shorter or longer time intervals to detect highly sporadic or occasional substance abuse. In practice, however, each has limitations and disadvantages that so far have discouraged their application by MMT clinics.[5] Urine assays remain the standard, with on-site urine-screening devices that provide results in minutes becoming more popular.[1]

In conclusion, 8 or 12 drugs screens per year are too many and of questionable value in some patients; whereas, weekly or biweekly screening can be far too few for others. Since progress in recovery during MMT is an individual matter and highly variable, rigid formulas dictating monitoring frequency at different stages are impractical and inappropriate from a therapeutic perspective.

It is important that MMT practitioners (and their patients) remain flexible and open to the value of very frequent drug screening during certain periods and only minimal screening at other times as patients achieve recovery goals.

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2. Is a person in true recovery 100% abstinent from illicit drugs and alcohol?  Yes;  Not sure;  No
3. Can a person "in recovery" be taking methadone?  Yes;  Not sure;  No
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5. Are you responding as a  Patient,  MMT clinic staff member, or  
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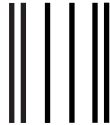
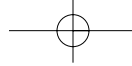
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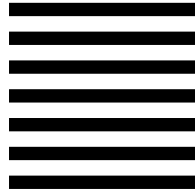
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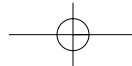


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