

Forum

THE QUARTERLY NEWSLETTER FOR CLINICAL HEALTH CARE PROFESSIONALS ON ADDICTION TREATMENT

Vol. 15, #1 • Winter 2006

MMT programs may benefit as the criminal justice system becomes enlightened to the advantages of treatment for opioid addiction.

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AT Forum is made possible by an educational grant from Mallinckrodt Inc., a manufacturer of methadone & naltrexone.

Current Comments

MMT in the Criminal Justice System

When it comes to addiction treatment in general, and methadone maintenance treatment (MMT) for opioid addiction in particular, the American criminal justice system has not been immune from the stigma, prejudice, and misunderstandings that have affected the rest of society.

However, there are glimmers of hope, as some courts, jails, and prisons become enlightened to the benefits of treatment for addictive disorders. This may offer new opportunities for MMT programs.

Drug-Related Crime a Problem

In 2003, there were 1.7 million arrests for drug law violations, making it the most numerous type of crime in the country (CSAT 2005). Today, 80% of prisoners have substance abuse problems, 20% have histories of heroin abuse, and as many as 30% of all inmates are injection-drug users (Rich et al. 2005b).

Researchers have estimated that 500,000 arrests per year involve risk for acute opioid withdrawal in prisoners following detention. Some of that may involve methadone withdrawal, since it has been estimated that 10% of all MMT participants around the country are arrested and jailed each year (Fiscella et al. 2005).

Therefore, this is a problem of some urgency for MMT programs and patients, and solutions may start with the courts.

The DTC Movement

America's "war on drugs" during the 1980s overloaded the courts and resulted in enormous numbers of incarcerated prisoners, which led to the birth of the Drug Treatment Court (DTC) movement. It was recognized that "lock 'em up" solutions failed to help prisoners. And, it

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Practice Pointers

How to Safely Discontinue Opioid Painkillers

Lee A. Kral, PharmD, BCPS

Hurricanes last fall in the Gulf Coast states caused many hardships for patients and healthcare providers alike. One of the concerns that came to light during this time of crisis was access to opioid painkillers (analgesics), such as those taken daily by patients with chronic pain and those enrolled in methadone maintenance treatment (MMT) programs. In many cases, MMT patients were cut off from their supplies of both methadone and additional opioid analgesics prescribed for pain conditions. This article addresses various options for safely managing the tapering of opioid pain medications.

MEDICATION TAPERING

Differing Objectives

In MMT programs, the use of tapering protocols is mainly aimed at preventing opioid withdrawal (usually from methadone). In the chronic-pain management setting, the desire is not only to prevent withdrawal but also to prevent recurrence of pain or rebound pain if the dose is reduced too rapidly. Sometimes these situations overlap, as in MMT patients having chronic pain, which increases the complexity of their medical management.

Opioid analgesic tapering may be done within the MMT setting, in specialty clinics, or in primary care practices. Protocols vary between institutions and outpatient centers, and many inpatient programs have converted to partial hospitalizations or intensive outpatient programs.

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Events to Note

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

March 2006

Society of Behavioral Medicine 27th Annual Meeting

March 22-25, 2006
San Francisco, California
Contact: 856-439-1297; www.sbm.org/

American Counseling Association Annual Convention

March 30 - April 4, 2006
Montreal, Quebec, Canada
Contact: 800-347-6647; www.counseling.org

April 2006

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

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

May 2006

Midwestern Psychological Association 78th Annual Meeting

May 4-6, 2006
Chicago, Illinois
Contact: MPA@depaul.edu;
www.midwesternpsych.org

ASAM (American Society of Addiction Medicine) 37th Annual Conference

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

American Psychiatric Association Annual Meeting

May 20-25, 2006
Toronto, Canada
Contact: 703-907-7300; www.psych.org

June 2006

College on Problems of Drug Dependence (CPDD) 68th Annual Meeting

June 17-22, 2006
Scottsdale, Arizona
Contact: 215-707-3242; www.cpdd.vcu.edu/

37th Annual New England School of Addiction Studies

June 5-6, 2006
Storrs, Connecticut
Contact: 207-621-2549;
www.neias.org/SS/SATSSCATTC06x.html

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847-392-3937 or submit it via e-mail from
www.atforum.com]

Straight Talk... from the Editor

MMT Agencies & Clinics Do Respond in Crisis

A feature article and editorial in our Fall 2005 edition of *AT Forum* (Vol. 14, #4), following devastating hurricanes in the U.S. last August-September, focused on disaster preparedness. Specifically, we reported on some failures of planning, along with inadequate responses, and suggested immediate ways that clinics and patients might help soften the blow of future crises.

In fair balance, and in followup, we have received some encouraging information about the fates of methadone maintenance treatment (MMT) patients late last summer, as well as news of federal plans in the works to help improve disaster response in the future.

Texas MMT Providers Mobilize Response

Farrukh Shamsi, Board Member & Immediate Past President of the Texas Methadone Treatment Association (TMTA) wrote in January, "I felt that you focused on many aspects of the aftermath of hurricane Katrina, but a large amount of attention was given to what went wrong following this disaster and the lack of medication available to clients/patients."

"I would like to relate to you first hand what happened in Texas. Within a few days of patients/clients arriving in OTPs (opioid treatment programs) in Houston and in other areas of Texas, TMTA was communicating with decision makers within the State Methadone Authority and with OTPs throughout the State (members and non-members)."

"I would like to commend both Mr. Calvin Holloway, Methadone Services Coordinator, and Mr. Wayne Gordon, OTP Team Leader/Manager, of the Texas Department of State Health Services for their assurances that we could medicate these displaced individuals using the minimum amount of information available. They also assured us that funds were going to be secured for medication services at private programs (many private programs already were providing free services on a humanitarian basis)."

"Publicly-funded programs functioned efficiently, but were in some cases filled beyond capacity. The fact that private programs had been authorized by the State to help was a huge plus. The ultimate goal was to medicate as many persons as possible, wherever possible."

"TMTA also contacted the 3 major manufacturers of methadone, and all provided assurances of uninterrupted

and, in some cases, free methadone supplies for Louisiana and Texas. On the whole, anyone needing methadone medication was taken care of."

"The programs that remained open in Louisiana, especially in Lake Charles and 2 in the outer New Orleans area, functioned admirably in the face of a large influx of patients/clients (and are still doing so to this day with 4 programs out of commission). They received emergency methadone supplies as needed."

"I did not hear of any cases of rigidity or pressure to collect fees from patients (the State was assuring the OTPs in Texas of forthcoming funding). In fact, there were an overwhelming number of cases of an outpouring of humanity, and general assistance, job, housing, and food referrals were being made. Yes, I am sure that there were incidents of confusion, but on the whole, the system worked and human beings were taken care of."

"Even with the best intentions and planning, emergency disaster plans do not always function correctly. In this case, patients/clients were given compassionate care (at the request of TMTA sent to all OTPs in the State of Texas). If there could be a natural disaster without any stress or any problems, we would be living in a perfect world."

Federal Government Building a Better Future: OTDS

According to all reports, SAMHSA (the Substance Abuse and Mental Health Services Administration) responded quickly and in full force in the wake of the hurricanes. Staff members from CSAT/DPT (SAMHSA's Center for Substance Abuse Treatment, Division of Pharmacologic Therapies), which oversees MMT programs, personally visited storm-devastated areas and provided funding as well as assistance to affected programs.

Now the agency is planning to step up efforts started in 2001 to better serve MMT patients in times of disaster. Arlene Stanton, PhD, NCC, Social Science Analyst with CSAT/DPT, told *AT Forum*: "The terrorist attacks on September 11, 2001 had an immediate and profound impact on New York City's opioid treatment system. One OTP, in the immediate vicinity of the World Trade Center, was destroyed. Several other OTPs were closed for days or even weeks. In all, it is estimated some 1,000 patients were displaced. Despite the chaos and terror

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surrounding this tragic event, patients sought treatment and staff and administrators in the New York metropolitan area kept other OTPs open, serving their own as well as these displaced patients."

"In August, 2005, history seemed to repeat itself as Katrina, the costliest and deadliest hurricane in United States history, inflicted catastrophic damage in Louisiana, Mississippi, and Alabama. In the days following, 80% of the city of New Orleans was flooded as the levees were breached. All 7 New Orleans OTPs were shut down for an extended period of time, and months later, many remain closed. As with 9-11, staff at other programs were forced to make dosing decisions, in many cases based upon the information provided by the patients themselves."

"Immediately after the events of 9-11, working with a number of key stakeholders from New York, Connecticut, and New Jersey, CSAT developed a feasibility and planning study focusing on developing a system that would ensure patients could safely and appropriately be dosed in the event that a disaster or other event resulted in closure of one or more treatment sites."

"In Fall, 2005, SAMHSA/CSAT funded a project to implement a limited pilot of the system, starting in the metropolitan New York area. From the beginning, the project has been guided by 4 principles: simplicity, affordability, acceptability, and confidentiality."

"Called OTDS (Opioid Treatment Data System for potential disasters), the pilot project will entail development of and implementation of a system to support the retrieval of limited patient dosage information in the event of such major disasters, and also more common disruptions in service due to snow storms, power failures, and other localized events. The system being piloted will use a biometric device, such as a fingerprint scanner, to store recent dosage information in a centralized database. Should a patient need to seek treatment at a program other than where they are normally enrolled, the 'guest' OTP will be able to verify that the person is a patients, and then retrieve a report on that patient's prescription and dosage information simply by scanning the patient's fingerprint."

"The current project will involve development of the necessary infrastructure, followed by a pilot test in 50 OTPs to determine the system's effectiveness in supporting OTPs' disaster preparedness and recovery activities for any discontinuity in service. The pilot system will be

reviewed to determine its effectiveness and ability to support a national implementation, should funding for such a system become available."

Brief Updates...

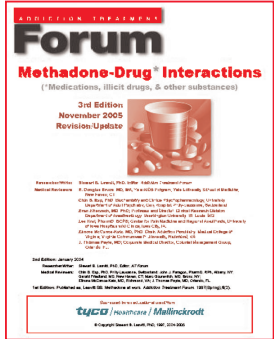
Methadone-Drug Interactions, 3rd Edition Released

During clinical use in the maintenance treatment of opioid addiction, spanning more than 40 years, oral methadone has proven to be a well-tolerated medication with minimal adverse

reactions when prescribed in appropriate doses and taken daily as a component of MMT. However, as the tables in this document indicate, there are more than 100 substances – medications, illicit drugs, OTC products, etc. – that can interact in some fashion to affect a patient's response to methadone.

Such interactions may be potentially harmful and/or can lead to treatment failures; although, they can usually be avoided or minimized. Released last November, 2005, exclusively as a web-based offering in PDF format for free download, this latest edition of *Methadone-Drug Interactions* reflects numerous changes since the last update in 2004. Additionally, it is more extensively referenced, with several levels of evidence denoted to indicate the validity of interactions.

To access and download the 31-page paper visit ATForum.com and look under the "Rx Methadone" tab.



New Website Attacks Pain



AT Forum readers interested in pain and its treatment should visit our new 'sister' website, *Pain Treatment Topix*, at Pain-Topix.com. Modeled after AT Forum, and sponsored by Mallinckrodt Pharmaceuticals Inc., this new offering is a non-commercial, open-access resource for healthcare professionals. It provides evidence-based clinical news, information, research, and education on the causes and treatment of pain, including acute, chronic, and terminal (end-of-life) pain conditions. A special section examines the interface of pain and addiction.

AT Forum Celebrates "Golden Anniversary"



This marks the 50th consecutive edition of *Addiction Treatment Forum* since our premiere issue in 1992. The MMT field has changed considerably during the past 14 years and *AT Forum* was privileged to be there, reporting on news, research, and information of interest and importance to our thousands of readers. All past editions are available online at our website, ATForum.com.

Looking at MMT in the Courts, Jails, & Prisons

This edition marks the first time *AT Forum* has examined methadone treatment for opioid addiction in the criminal justice system. This also will be featured at the upcoming AATOD Conference in April and we will report on this in our Spring edition. Meanwhile, we hope readers will respond to our survey on this subject (below).

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NEW SURVEY: Methadone in Jail/Prison

Please respond to the following survey questions:

1. Have any patients at your MMT clinic been incarcerated during the past year?
 Yes; No.
2. What typically happened to them in jail/prison? Methadone maintenance was continued; Methadone withdrawn gradually; Forced to withdraw 'cold turkey'; Don't know; Other (specify) _____.
3. Has your clinic received any new patients during the past year referred from the criminal justice system?
 Yes; No; Don't know.
4. Are you responding as an MMT patient, or an 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.

was discovered that coerced treatment for addictive disorders in lieu of incarceration was as effective as voluntary treatment (CSAT 1993; Hora 2004).

From the first DTC – started in 1989 in Miami, Florida – growth has been enormous. Today, there are more than 1,600 drug courts in the U.S., with 70,000 program participants and 16,000 annual ‘graduates’ – persons successfully completing their court-supervised treatment programs (Huddleston et al. 2005).

Drug court participants undergo an intensive regimen of substance abuse and mental health treatment, case management, drug testing, and probation supervision while reporting for regularly scheduled status hearings before a judge with expertise in the DTC model (CSAT 2005; Huddleston et al. 2005).

These courts have demonstrated that they “...outperform virtually all other strategies that have been attempted for drug-involved offenders...” (Marlowe et al. 2003), and at very favorable benefit-to-cost ratios (Finigan 1999).

However, it has been suggested that these courts can improve by mandating ongoing program participation following completion of the primary, court-ordered treatment episode (Christoff 2005). MMT programs should be ideally situated to meet these needs for opioid addicts.

Unfortunately, the courts have historically been hostile to MMT. Judges have sometimes required defendants to stop or taper methadone as a condition of admission to or graduation from the DTC program. A few alarming cases highlight these problems (Hora 2004):

- In 2002, a DTC participant in California was ordered to stop methadone therapy, and 2 months later died of a heroin overdose. The judge, who had never consulted a physician about the case, noted: “...if a person chooses not to be a drug addict, they can also choose to not be addicted to methadone.”
- In 2003, a Virginia woman, who had been prescribed methadone for treatment of oxycodone addiction, was sentenced to 3 years in prison for violating a probation condition prohibiting her from taking methadone.
- In New Hampshire, a judge ordered the County jail to allow an inmate to continue MMT during his 270-day sentence. However, the State Supreme Court overturned that order, claiming it was too costly for the jail to transport the prisoner for methadone treatment.

Therefore, with relatively few exceptions, it appears that DTCs do not welcome



the participation of MMT programs. There is untapped potential, but also an ongoing need for the education of court personnel by MMT programs.

Methadone in Jails/ Prisons

One survey of State and Federal prison medical directors found that 48% use methadone, however, this was almost exclusively for pregnant inmates. Only 8% of respondents referred opioid-dependent inmates to MMT programs upon release (Rich et al. 2005a).

Another national survey found that very few jails used methadone (1%) or other opioid agents (2%) to assist in opioid withdrawal, and 85% did not continue methadone for inmates who were participants in community MMT programs. Three-quarters of jails did not even contact the MMT programs about inmates under their care (Fiscella 2005; Fiscella et al. 2005).

Certainly, poor or nonexistent coordination between correctional facilities and community-based MMT programs worsens problems of managing incarcerated patients. For example, without accurate information about current dosing, correctional healthcare providers cannot make informed decisions about methadone management (Fiscella 2005). And, as noted earlier, this is of concern because 1 in 10 MMT participants may become entangled in the criminal justice system during any year (Fiscella et al. 2005).

Linking MMT and the CJS

During incarceration and following release from jail or prison are ideal times to link opioid-addicted persons to substance abuse treatment. In this regard, MMT provides benefits to individuals and their communities at one-fifth the cost of incarceration (Rich et al. 2005b).

The innovative KEEP (Key Extended Entry Program) model developed in the New York Metropolitan area in 1987 enables opioid-dependent offenders to be maintained on methadone during their stay at Riker’s Island Correctional Facility (CSAT 2005). In 2001 it was reported that

the KEEP program had 4,000 inmates admitted to MMT annually, and upon release they were referred to participating community MMT programs (Tomasino et al. 2001). *Also see interview with Mark Parrino in this edition.*

In 2002, the most recent year full data were available, the criminal justice system (CJS) was a major source of referrals to addiction treatment programs overall, accounting for 655,000 patients or 36% of all admissions. However, only 7% of all CJS referrals involved opioid abuse and dependence (SAMHSA 2004), and the number of referrals to MMT programs was probably quite small; although, the specific numbers are unknown.

Thus, data and information coming from various directions clearly highlight the need to de-stigmatize the use of methadone in the incarceration setting, expand access to methadone during incarceration, and to improve linkages to MMT programs for opioid-dependent offenders who return to the community (Rich et al. 2005a).

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Interview: Mark Parrino, MPA – MMT Can Serve Courts, Jails

At the upcoming AATOD Conference in Atlanta, Mark W. Parrino, MPA – President, American Association for the Treatment of Opioid Dependence (AATOD) – will be joined by Paul Samuels (President and Executive Director, Legal Action Center), Martin Horn (Commissioner, New York City Department of Corrections), and Timothy Ryan, Chief of Corrections, Orange County, Florida, in providing a summary and perspective for the methadone maintenance treatment (MMT) community on “Working with Criminal Justice and Healthcare Systems.” In advance of that, AT Forum contacted Parrino for his outlooks.

AT Forum: Have the criminal justice system (CJS), overall, and Drug Treatment Courts (DTCs), in particular, been supportive of MMT?

MARK PARRINO, MPA: Most criminal justice entities and their representatives traditionally have *not* been supportive of addiction treatment specifically for opioid addiction, and they certainly do not support the use of medication assisted treatment that includes methadone or buprenorphine. At present, we don't know just how many people are actively referred from the courts to methadone programs in the United States.

When it comes to jails and prisons, I think Tim Ryan put it best when he told me the general perspective is that their jails have been used traditionally for imprisonment, without focusing on the physical and mental health needs of inmates. Today, they're faced with resolving problems that were not attended to while these inmates were free in the outside society.

ATF: Do you think healthcare and addiction treatment are legitimate concerns for the criminal justice system?

PARRINO: Given the lifestyles of most people who find themselves behind bars, the necessary connections for care cannot be made or are unlikely to be made in the outside world. Following incarceration, they are a captive audience and their lives are basically put on hold while necessary access to healthcare and addiction treatment can be made.

The Riker's Island experience is the proof of concept that this works. This program goes back to 1987, they treat 4,000 inmates per year with methadone, and following release more than 70% of those inmates report to an MMT program in the community.

ATF: What's the benefit for the average MMT program?

PARRINO: If nothing else, it could mean a new source of patient referrals from drug courts, probation officers, and from jails and prisons. This is an opportunity for MMT clinics to partner with a new constituency.

ATF: Aren't many or most MMT programs already filled to capacity?

PARRINO: That's a common myth. In a small number of cities MMT clinic case loads might be at capacity, with waiting lists or a scarcity of treatment slots. And some states – such as, Oregon – have cut funding for MMT, while others – like Ohio – have not expanded the number of existing programs for many years. However, generally speaking, we don't receive many calls complaining about patients not being able to access treatment due to insufficient capacity.

Furthermore, we know that a certain percentage of existing MMT patients will become embroiled in the criminal justice sys-

tem and some will be incarcerated. It makes sense for these patients to continue to receive access to care while in jail; rather, than facing a destabilizing situation during their short-term period away from the MMT clinic – usually, less than 120 days.

It's good for the patient and it's good for the MMT program, since the patient will return to them still stabilized and they don't have to go through the long process of restarting methadone and reaching stabilization. It becomes more like treating the MMT patient during an extended hospitalization.

ATF: Should MMT programs be making an effort to partner with drug courts and criminal justice agencies?

PARRINO: Yes; however, no one presentation, no single initiative, will be enough. It takes time. That's why the Robert Wood Johnson Foundation Innovators Award we've received, combined with funding from Mallinckrodt Inc., is a long-term project that has focused on information gathering and active support of programs. For example, we've met with representatives of the Maryland Department of Public Safety and Corrections in order to guide them toward policy changes and their implementation. Effective last July, they introduced methadone into the Baltimore City jail system. We've recently looked at helping the New Mexico jail system in the same way.

There are still several impediments, such as funding for MMT within the justice system. Negative attitudes of senior wardens and staff regarding this issue are another concern; generally speaking, they do not want to provide methadone unless they have to.

In one case, the Supreme Court of Vermont ordered that an MMT patient must receive methadone while incarcerated. The local MMT program in Massachusetts offered to deliver a week's supply at a time. Yet, rather than allowing that, authorities commuted the man's sentence and released him from jail without any addiction treatment.

There have been other cases in which justice system representatives – such as, parole officers or judges – disapprove of patients continuing on methadone, will not allow these persons to participate in drug court programs, and threaten them with immediate incarceration. However, at the same time, there are other courts around the country that will actively refer individuals to MMT programs.

ATF: Overall, then, it seems MMT programs can benefit from a heightened awareness throughout the justice system of methadone's benefits in treating opioid addiction.

PARRINO: Yes, however, some of the burden rests with MMT programs in helping to educate the courts and others within the justice system. A basic question is: Do MMT programs want more business; that is, do they want more patients available from this new referral source? If the answer is “yes,” then the next question is: Are they willing to go about making connections and educating decision makers in the justice system?

To assist in this endeavor, AT Forum is producing a new Special Report supporting MMT in the criminal justice system for distribution to judges, parole officers, and other authorities. Watch for it this Spring. – Editor

Duration of Taper

The duration of the taper depends on the patient's needs and the complexity. The universal goal is to taper as quickly as the patient's physiologic and psychological status allows. The presence of multiple physical disorders, polysubstance abuse, female gender, and older age are among the factors that increase the difficulty of tapering and tend to lengthen the duration of the taper as well. Patients with a long history of taking opioid analgesics also have more difficulty with withdrawal symptoms and require a longer taper. The most important consideration is to make decisions about therapy on an individual basis.

In response to the crisis in the Gulf Coast, a working group representing several organizations in the pain-management field published tapering schedules, "Recommendations to Physicians Caring for Katrina Disaster Victims on Chronic Opioids," which are found in *Table 1*.^[1] Furthermore, a Clinical Practice Guideline on Chronic Opioid Therapy from the U.S. Department of Veterans Affairs contains suggested tapering regimens for several different opioids (*Tables 2 and 3*).^[2] These recommendations assume that there is sufficient medication and time available for tapering.

Analgesics Used for Tapering

Depending on the situation, several options are available, and there is no tapering protocol that has been proven more clinically effective than another. In MMT patients, the regular methadone maintenance dose is continued during analgesic tapering.

The same analgesic the patient has been taking may be used, which can be accomplished even with short-acting analgesics; however, it is recommended that combination agents containing acetaminophen are minimized or converted to agents without acetaminophen. The average daily dose should be spaced evenly throughout the day (and "taken as needed [prn]" doses eliminated), usually with a frequency of every 4 or 6 hours. Once the patient has been stabilized on a scheduled dosing frequency, the tapering regimen may be implemented (*Table 2*).

Short-acting analgesics may be replaced with long-acting ones, such as

long-acting morphine, or long-acting oxycodone. Usually after a dosing conversion has been calculated, a "test dose" will be given with close monitoring. If the dose of the long-acting agent is too low, the patient may develop withdrawal symptoms; whereas, if it is too high, the patient may develop sedation. During the first week, the dose of the long-acting agent should be adjusted to control any withdrawal symptoms. After the patient has been stabilized, the tapering regimen may be implemented (*Table 3*).

Adjusting Tapering Regimens

Within addiction treatment programs, individual patients may have differing

Table 1. Katrina Disaster Working Group Suggested Tapering Regimens [1]

- Reduction of daily dose by 10% each day, or...
- Reduction of daily dose by 20% every 3-5 days, or...
- Reduction of daily dose by 25% each week.

Table 2. VA Suggested Tapering Regimens for Short-Acting Opioids [2]

- Decrease dose by 10% every 3-7 days, or...
- Decrease dose by 20-50% per day until you reach the lowest available dosage form (e.g., 5 mg of oxycodone)
- Then increase the dosing interval, eliminating one dose every 2-5 days.

Table 3. VA Suggested Tapering Regimens for Long-Acting Agents [2]

Morphine CR (controlled-release)

- Decrease dose by 20-50% per day until reduced to 45 mg/day, then...
- Decrease by 15 mg/day every 2-5 days.

Oxycodone CR (controlled-release)

- Decrease by 20-50% per day to 30 mg/day, then...
- Decrease by 10 mg/day every 2-5 days.

Fentanyl – first rotate to another opioid, such as morphine CR.

Medication Tapering in an Emergency – What Can Patients Do?

Following the Katrina Hurricane, the National Pain Foundation* offered some recommendations for what patients can do when all access to continuing pain medications is cut off, as during an emergency or other crisis. These are adapted here.

Symptoms of withdrawal will vary depending on how long you were on the opioid medication and what type you were taking. People taking morphine, hydromorphone, or oxycodone may experience withdrawal symptoms within 6 to 12 hours of the last dose while those taking methadone will experience symptoms 3 to 4 days after the last dose. Typically, withdrawal from morphine takes 5 to 10 days while withdrawal from methadone takes longer.

Ideally, tapering the medication would be a slow process under the care of a physician. If this cannot be accomplished, it is important to make an effort to taper the dose on your own as slowly as possible.

The best way to avoid serious withdrawal symptoms is to reduce the amount of medication you are taking or how often you are taking it before you run out. Reducing the amount by 25% per day, or by 25% every other day, may result in some withdrawal symptoms but it is better than having to suddenly stop the medication when you run out.

If you are taking any of the extended release versions of opioids, such as OxyContin® or Kadian®, or fentanyl patches, do not tamper with them in any way. Breaking or opening these capsules, or cutting patches, can release the whole dose at once,

causing overdose and death. Instead, take the whole pill or capsule or use the whole patch, but take or use the medication less often to reduce the dosage.

Drink a lot of fluid, try to stay calm, and keep reassuring yourself that the withdrawal reaction will pass and you will eventually feel better. One of the symptoms during opioid withdrawal is a state of sensitized pain, meaning your pain may feel more intense or severe. This also will pass with time.

Antidepressant medications also can produce withdrawal, but symptoms are generally milder than those of opioids. Withdrawal from antidepressants is more like an anxiety attack that leads to the return of symptoms from the original depression or anxiety.

Withdrawal from antidepressant medication can be prevented by reducing the dose as slowly as possible. If you take one tablet a day of an antidepressant, you can taper the dose by taking one every other day for a while before you stop or run out of medication. If you take several tablets a day, you can reduce the number to one or two a day until you run out.

Remember: Always seek professional healthcare assistance as soon as you can; if possible, before running out of medication.

*National Pain Foundation. Abrupt Withdrawal from Medications – Information and Caution. 2005 (Sept). Available at: http://www.nationalpainfoundation.org/MyTreatment/MyTreatment_Abrupt_Withdrawal.asp. Access checked January 16, 2005.

responses to the tapering regimen chosen. For those who have been on long-term opioid analgesic therapy, there may be fear and anxiety about reducing and/or eliminating their opioid medication. Patients may be concerned about a recurrence or worsening of pain, or the return of opioid cravings. They may be concerned about developing withdrawal symptoms, particularly since withdrawal-avoidance is part of the addiction pattern.

Typically, the last stage of tapering (less than 30-45 mg/day of opioid) is the most difficult. Often, regimens will need to be slowed at this point to prevent withdrawal (Tables 2 and 3). As long as the patient has been making a good effort and has followed through with the tapering plan, slowing the taper may be the most reasonable adjustment (also see, **Medication Tapering in an Emergency** sidebar).

Adjunctive Therapy

The symptoms of opioid withdrawal are not dangerous; however, they may cause considerable discomfort, including autonomic and noradrenergic symptoms such as diarrhea, nausea, cramps, sweating, tachycardia, and hypertension. Some healthcare providers add clonidine to reduce these symptoms. Antihistamines or trazodone may be used to help with insomnia and restlessness. Nonsteroidal anti-inflammatory agents may be used for muscle aches, dicyclomine for abdominal cramps, and Pepto-Bismol[®] for diarrhea.

In sum, although currently there is no standard protocol for tapering opioid analgesics, there are now some suggested guidelines. Regardless of the reason for tapering opioid analgesics, the plan must be individualized to each patient's needs. Close follow-up and psychosocial support are essential.

1. American Academy of Pain Medicine. Recommendations to Physicians Caring for Katrina Disaster Victims on Chronic Opioids. Available at <http://www.painmed.org/katrinarecommendations.pdf>. Accessed January 16, 2006.
2. U.S. Veterans Affairs Administration. Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain. 2003; Appendix Y:52-53. Available at http://www.oqp.med.va.gov/cpg/cot/ot_base.htm. Accessed January 16, 2006.

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New MOM Program Serves MMT Mothers

Last summer, a unique new program was launched to serve the special needs of pregnant and post-partum women receiving methadone maintenance treatment (MMT) and their newborns. The program provides a nurturing environment that often is lacking for these women, while dispelling myths and stigma frequently surrounding MMT.

Located at Kent Hospital in Warwick, Rhode Island, development of the MOM (Mothers on Methadone) program was spearheaded by Sharon Dembinski, PNP, CMA, who was joined by several medical colleagues. Its objective is to provide education and support services specifically for women in MMT during pregnancy, helping them to prepare for the births of their babies and providing needed follow-up care for the women and their newborns after delivery.

Comprehensive Services

MOM services include specialized counseling to assist in ongoing addiction recovery, prenatal education classes, and assistance in assuring that healthcare needs are met. After delivery, MOM staff are there to help explain what the newborn is experiencing and to offer ongoing support in dealing with an infant who is most likely being treated for opioid withdrawal, called neonatal abstinence syndrome (NAS), by specially trained staff.

The program extends beyond the hospital. After discharge, MOM staff continue to guide and support the women with phone consultations. Assistance also is provided, as needed, in making connections with community-based resources.

A Dedicated Leader

Prior to starting the MOM program, Dembinski, a pediatric nurse practitioner, went through training offered by the National Alliance of Methadone Advocates (NAMA) to become a certified methadone advocate (CMA). Combining her medical training and interest in addiction recovery, she founded the first NAMA chapter for mothers on methadone – the New England NAMA-MOM chapter.

Apart from her professional life as a nurse practitioner, Dembinski has personal experience with motherhood and children. In addition to 2 biological children and 3 adopted, she became a grandmother last summer. She learned about

Kent Hospital
Special Care Nursery
MOTHERS ON METHADONE
(MOM) PROGRAM



addiction when dealing with her son's heroin dependence and his experiences along a very difficult road to recovery. Patients within the MMT community helped educate her and interested her in becoming an advocate.

Successful Beginning

Since July 2005, when the MOM program started, Dembinski reports they've seen a 40% increase in the number of deliveries to methadone-maintained mothers at Kent Hospital. Actual numbers of patients are still small; however, perhaps more important is the testing of a program model that can be applied throughout the country.

Dembinski notes that the average length of hospital stay for their MOM-program babies with NAS has been 23 days, ranging from 5 to 42 days – which is to be expected. And, "So far, the Moms who've delivered are doing quite well, with the majority remaining in MMT and relapse-free," she says.

Adequate Methadone a Key

Of particular interest, she describes one woman who delivered 2 babies within a year's time. In the first pregnancy the woman was taking 120 mg/day of methadone (split 60 mg twice daily) during the last trimester. Her newborn required more than 6 weeks in the hospital for NAS. For the second birth, the woman had been prescribed 290 mg/day (145 mg twice a day) and this was started much earlier in pregnancy. This newborn required only 10 days for NAS treatment; well below the average.

Dembinski theorizes that when doses are increased appropriately and split earlier in pregnancy the woman is more adequately stabilized and the fetus does not develop an adverse reaction to periodic withdrawal while in the womb. Consequently, although the newborn will still have signs of withdrawal, the more dramatic signs and symptoms of NAS are avoided and treatment for NAS proceeds more smoothly and quickly.

Of course, this needs to be verified by research studies. However, it further supports the notion of providing adequate methadone during pregnancy and the MOM program may well become a proving ground as its success continues and grows in the months ahead.

AT Forum Survey Results: Recovery?

The Summer edition of *AT Forum* (Vol. 14, #3) had a brief notice about National Alcohol & Drug Recovery Month (September 2005) and a reader survey on "What is Addiction Recovery?" While survey responses were still being collected, there was a feature article on addiction recovery in the last edition of *AT Forum* (Fall 2005, Vol. 14, #4).

A person in addiction recovery...	YES	NO	NOT SURE
...is free of the disease of addiction?	12%	82%	6%
...is 100% abstinent from illicit drugs/alcohol?	61%	30%	9%
...can be taking methadone?	89%	5%	6%
...has a renewed sense of spirituality?	60%	26%	13%

In total, there were 215 survey responses: 40% from methadone maintenance treatment (MMT) clinic staff; 30% from MMT patients; and, 30% from "others." This last category included private practice healthcare providers, mental healthcare workers, former patients, relatives, and assorted other persons.

Enlightened Views Expressed

The *Table* depicts a summary of answers to the 4 questions asked of readers. For the most part, these responses depict an enlightened view of addiction, recovery, and methadone maintenance.

More than 8 out of 10 respondents indicated that a person in recovery is *not* necessarily free of the disease of addiction. This recognizes that addiction is genuinely a chronic disease and that recovery does not involve 'curing' the disease itself.

Roughly 60% believe a person in recovery must be completely abstinent from all illicit drugs and alcohol. It is somewhat concerning that 3 out of 10 respondents would accept some use of alcohol or drugs. Some readers suggested that the primary focus of recovery is on avoiding only the 'drug of choice' that created problems for the individual; however, this notion would be strongly disputed by many in the treatment community.

Almost all readers – 89% – indicated that ongoing methadone maintenance is not an exclusion for addiction recovery. However, it must be acknowledged that most *AT Forum* readers, and survey respondents, would be expected to view MMT favorably.

Finally, 6 out of 10 respondents believe that a renewed sense of spirituality is essential for recovery. This might reflect a 12-Step program orientation, which has proven helpful for so many persons in recovery through the years. Still, slightly more than a quarter of respondents feel this is unimportant, and it appeared that clinic staff were much more doubtful about the importance of spirituality than were patients or others.

Recovery An Individual Experience

As the *AT Forum* article last fall suggested, recovery has many aspects, which extend beyond avoiding illicit drugs/alcohol and following MMT clinic rules – it is a very individual experience. Here are a few comments from patients:

"I will never be 'free' of the disease. I just have to do my best and I've used illicit drugs only once in the 13 years I've been on methadone (at the very beginning). So, methadone has saved my life."

"I believe a person in recovery is 100% abstinent, but a person who relapses and immediately gets back into the program that was helping them is still in recovery."

"I tried the traditional 12-Step (God) programs and felt that I was being brain-washed. I was shunned for my non-belief and, in their views, I did not belong because I was taking methadone."

NOTE: SAMHSA (the Substance Abuse and Mental Health Services Administration) has launched a new website called "Partners for Recovery (PFR)." This site is intended to facilitate communication and resource-sharing for organizations and groups that help individuals and families achieve and maintain recovery. Among other offerings, PFR features news and documents on recovery and stigma reduction. See: <http://www.pfr.samhsa.gov>.

ADDICTION TREATMENT

Forum

is published quarterly by:

Clinco Communications, Inc.
P.O. Box 685
Mundelein, IL 60060
Phone/Fax: 847-392-3937

Editor: Stewart B. Leavitt, PhD

Publisher: Sue Emerson

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Addiction Treatment Forum is made possible by an educational grant from Mallinckrodt Inc., a manufacturer of methadone and naltrexone. All facts and opinions are those of the sources cited. The publishers are not responsible for reporting errors, omissions or comments of those interviewed.

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