

Forum

THE QUARTERLY NEWSLETTER OF ADDICTION TREATMENT FOR CLINICAL HEALTH CARE PROFESSIONALS

VOL. 1, #2

In The News...

Clinics/Programs Face "Rocky Road"

According to a surge of newspaper articles from around the country this past summer, some addiction treatment clinics or programs are facing tough times. Following is a brief selection of clips collected by our editors:

The limit would include... methadone treatment for only two years

• "Limits on Drug, Alcohol Treatment Possible" — Northampton County, PA

[Express-Times, June 5, 1992] — County officials want to scale back the amount of drug and alcohol treatment a patient can receive. This would in effect allow the county to provide less treatment for more patients. The limit planned by the county would be \$10,000 per patient. The limit would include: one detoxification a year; one long-term stay in a rehabilitation center in a lifetime; and methadone treatment for only two years with a possible 1-year extension based on appeal. The executive director of a drug treatment program who opposes the cap stated, "Relapse is part of recovery. Saying you can only have one rehab in your lifetime is like telling someone they're only allowed to get treatment for one heart attack in their life." The people in the methadone program who will be effected most by the limits are those with low paying jobs that do not receive state Medical Assistance. They typically pay \$30 per week for treatment. That cost could increase to

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Current Comments

Is There a "Best" Addiction Treatment?

In the article, "Opioid Addiction Treatment Modalities and Some Guidelines to Their Optimal Use" which appeared in the April-June, 1991 issue of the *Journal of Psychoactive Drugs*, the authors, Richard A. Rawson, Ph.D. and Walter Ling, M.D., contend that opioid addicted persons contacting a particular treatment program are usually presented one modality as the only acceptable form of treatment. "Other forms of treatment are either ignored or disparaged." *A.T. Forum* interviewed Dr. Rawson, who is Executive Director of the Matrix Institute on Addictions, Beverly Hills, California, for current comments on this outlook.



A.T. Forum: Dr. Rawson, is there such thing as a "best" modality of treatment for opioid addiction?

RICHARD RAWSON, Ph.D.: The "best" form of treatment for an intravenous heroin user is that which engages him or her in treatment in the most rapid way possible. We view IV heroin use as a life-threatening condition given the dangers of heroin use itself, as well as the potential for contracting HIV. The most optimal form of treatment is often unclear at the admission stage, so the real key to the

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YOUR participation will make this publication a true forum; a dialogue in print

Straight Talk... from the Editor

YOUR Feedback Counts the Most

Thank you... for your very positive reception of our premier [summer 1992] edition of *A.T. Forum*. Apparently, we were right on target by providing a well-balanced mix of useful information. As one reviewer said, "Addiction professionals just don't have much time to read, unless they're among the relatively small number engaged in research. A publication like yours is doing a great service by giving them up-to-date, useful information in a quick-to-read format."

We were pleased with the number of feedback cards mailed to us requesting literature reprints [apparently, there is a hunger for more complete information among many readers] and to add names to our mailing list. Our only disappointment was the scarcity of letters offering comments, opinions or suggestions. YOUR participation will make this publication

a true forum, a dialogue in print for all addiction treatment professionals. So, take a few minutes and send us a note at the address listed below.

As you know, the field of addiction treatment is complex and rapidly changing. Thus far, we've only started our exploration of the many topics that might be of concern to readers. In future issues of *A.T. Forum*, we will be looking into addiction treatment and pregnancy, clinic operations, the pharmacology of addiction treatment medications, alternative treatment modalities and other issues. Of course, we expect to continue coverage of HIV/AIDS, legislation, current news and research issues as they relate to the topic. We invite your contributions to share your insights and experiences with fellow professionals.

ATF Seeks to Share Info About Advocacy Groups

As a special service to readers, we would like to collect and share information about the many Methadone Patient Advocacy Groups around the country. Send us the important facts (contact persons, goals, etc.) of your group and we will make the information available via the feedback cards.

How do you reach us? Use the feedback card in this issue, or write to us at: *AT Forum*; 1515 Woodfield Rd.; Suite 740; Schaumburg, IL 60173. Be certain to include a phone number where we can reach you during business hours to verify information.

Stewart B. Leavitt, Ph.D., Editor

Forum Feedback

"Congratulations on an excellent premier issue of *A.T. Forum*. It is unfortunate that many professionals do not understand narcotic addiction or how methadone works. This results in methadone being administered improperly, e.g., low-dose methadone. These unsound medical procedures put the very lives of methadone patients at risk, whether from relapse to heroin use or the danger of infection with HIV."

"In spite of the adverse position that many methadone patients find themselves forced into because of such improper treatment, NAMA has been impressed with the many patients who have nonetheless found a way to make methadone maintenance treatment work for them. Because of this situation, we would like to see more in your future issues on the pharmacology of methadone and how it actually works in the treatment setting."

*Joycelyn Woods, Vice President
National Alliance of Methadone Advocates (NAMA), New York, N.Y.*

[Following are comments from a response letter sent to us by "Doris," the patient featured in the "Patient's Perspective" section of the Summer 1992 *A.T. Forum*. - ed]

"Concerning the end of the article which stated, 'I will not seek detoxification again until I have resources to overcome the pain, enough courage to overcome the fear and enough faith to overcome the odds': I would prefer to leave with your readers a more positive impression of my experience and my success in coming to terms with my status as a patient; proud (that I asked for help and made a very wise decision); and confident (that MMTP is the best course of treatment for my disease)."

"Too many successful MMTP patients melt into the woodwork and, given the social stigma of being in an MMTP, have no intentions of standing up to be counted.... Consequently, the unsuccessful patients receive all the media attention and the negative image is reinforced."

A.T.F.

A.T.F.

Drug Abuse Alert

Heroin- & Cocaine-Related Emergencies Increasing

According to NIDA's Drug Abuse Warning Network (DAWN), drug-related visits to hospital emergency rooms, especially for heroin- and cocaine-related problems, continue to climb significantly. From the second to the third quarter of 1991, cocaine-related emergencies increased 13 percent; emergencies stemming from heroin abuse rose 10 percent.

Comparing the third quarter of 1991 with the same period a year earlier, an article in the *Seattle Times* [July 24, 1992] noted five cities — Seattle, Baltimore, Detroit, New York and Newark — as having startling increases of emergency cases dealing with heroin overdoses. While Seattle still has far fewer heroin addicts than the other mentioned cities, the 225% [see chart] increase in its emergency cases (from 63 to 205) has sounded an alarm.

The U.S. Department of Health and Human Services has authorized \$800,000 for the Seattle/King County Health Department to use in treating heroin addicts via methadone and counseling. The article notes there is widespread concern that "a purer and more potent form of heroin has been entering the country in record amounts and attracting a new generation of heroin users." The money to the cities will be made available from selling

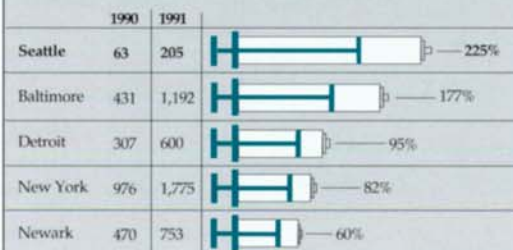
property seized from drug traffickers by the U.S. Drug Enforcement Administration, says the article. [In total, an estimated \$5 million in such funds will be made available to the five cities mentioned above; \$19 million to cities nationwide, including an amount to Los Angeles where recent rioting disrupted drug abuse prevention and treatment services.]

The July/August 1992 edition of *NIDA NOTES* mentions, "NIDA began receiving anecdotal evidence of increases in drug abuse in late 1990. The evidence included accounts of increased snorting of heroin as well as reports that older, experienced drug users were switching to heroin in Chicago, Newark, Miami, and San Francisco."

In response to the current DAWN data and other fact gathering by NIDA, Health and Human Services Secretary Dr. Louis Sullivan has urged Congress to approve President Bush's fiscal year 1993 budget request for an increase of \$248 million for drug abuse treatment. He reportedly warned that without increased treatment capacity, the number of drug-related emergency cases will continue to climb.

Cities with growing heroin problems

Numbers of people treated in emergency rooms for heroin overdoses increased significantly in these cities in the third quarter of last year, compared with the same period the year before.



Source: National Institute of Drug Abuse, Drug Abuse Warning Network

News Brief...

Heroin Sniffing Plague Moves to Midwest

According to the *Chicago Tribune* [Robert Blau, July 23, 1992], snorting a high quality brand of heroin called "China White" is becoming ever more popular among addicts. Experts are concerned that "a heroin crisis is taking shape in Chicago, mirroring a trend in New York, Boston and Newark, N.J., where more potent doses of the drug are being sold at cheaper prices than ever before."

A large increase in the number of heroin users is expected well into the next century, although crack cocaine continues to dominate the Chicago scene. Historically, Chicago has been a major market for brown Mexican heroin that was 1 to 2 percent pure. More potent white powder from Southeast Asia began appearing in the late '80s. The option of inhaling the drug has made heroin more attractive to users who would otherwise shun IV injection, with its potential for spreading HIV. This has opened the door to drug addiction for a whole new generation of users.

According to the article, Chicago's treatment centers are seeing rapid increases in the number of heroin users seeking help: 7,738 in fiscal 1992, compared with 5,309 in 1991 and 4,141 in 1990. "The increase comes at a time when budgets for state-funded treatment programs are shrinking and availability of the drug is rising."

Grant Applications Requested: Clinical Research on Human Development & Drug Abuse

[Reported in *NIDA NOTES*, July/August 1992] "NIDA is seeking grant applications for an ongoing research program on the effects of drug abuse on human development as it relates to prenatal and environmental exposure to drugs, child abuse and neglect by drug-abusing parents or guardians, and other factors associated with developmental and intergenerational patterns of drug abuse and the transmission of AIDS."

A broad variety of research modalities will be considered for funding. "Research studies using animal models to investigate clinical questions are encouraged, as are studies of clinical and legal issues related to drug screening, risk assessment, parent and child rights, drug abuse treatment, child custody, and interventions for the child."

For a copy of the Program Announcement [PA 92-58], contact NIDA's Grants Management Branch at 301/443-6710.

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"Best Treatment" continued from Page 1

treatment process is getting addicts into the treatment system as soon as possible.

Once they are engaged in the treatment process, they can be directed into a treatment plan that will provide the best form of assistance for their range of needs. What we find, though, is that often when addicts contact the treatment system, the people that they first contact try to convince the addicts of the superior value of one particular form of treatment.

If the addict isn't amenable to that point of view and disagrees

with that form of treatment, the addict is criticized and told he is in denial or isn't ready for treatment and should come back as soon as he is able to see clearly that the treatment program's approach is valid. The professionals do not help find other treatment programs that might be more compatible with the addict's perspective on addiction.

A.T.F.: In your article, you provide a table of values and beliefs about opioid addiction which influence treatment modality recommendations [see Table 1]. It also seems that an addict might find himself in one kind of program versus another depending upon his socioeconomic position.

RAWSON: That's the way the system has evolved. In the public sector, we've had therapeutic communities and the methadone treatment programs. Treatments like naltrexone [which blocks the effects of heroin] and clonidine [to ease detoxification] are medications which have come out of the research arena and, in many cases, have stayed fairly restricted to research kinds of settings. LAAM [a long-acting opiate maintenance medication] and buprenorphine are currently undergoing study. The public sector and the research arena have typically served patients from lower income and/or minority groups.

The 28-day program has come out of the private sector. In the 28-day program, you've had primarily middle class and upper middle class alcohol abusers and, now, prescription and intravenous opiate users. The treatment modality they are first exposed to is the 28-day treatment system. So, often they go into that treatment system without any evaluation of whether or not that's the most appropriate one for them.

A.T.F.: What has been the greatest

Table 1

Values and Beliefs About Opioid Addiction and Opioid Addiction Treatment

Category	Statement of Position(s)	The Effect on Opioid Addiction Treatment or Antidrug Social Intervention
Values	Everyone should work and contribute to society	Vocational counseling Employment as a measure of treatment effectiveness
	One should not be dependent on drugs to cope with life's problems	Medication-free treatment
	Staying off heroin is more important than being medication free	Methadone or other opioid agonist therapy
Belief about the cause of heroin addiction	A moral failing	Narcotics Anonymous
	Social deviance or sociopathy	Criminal justice system
	Inadequate skills to cope in mainstream society	Long-term therapeutic community
	A manifestation of psychiatric disorder	Psychiatric medication, psychotherapy or both
Belief about the pathophysiology of heroin addiction	Ignorance about the dangers of heroin	Drug education in the schools
	A temporary biochemical disturbance	Detoxification or short-term methadone maintenance
Belief about the cause of relapse to heroin	A permanent biochemical abnormality	Lifetime opioid replacement with methadone or other opioid agonist
	Most addicts would be less likely to relapse if they knew about the dangers of heroin	Drug education as a component of treatment
	Addicts will not use heroin if they cannot feel its reinforcing effects	Blockade of response to heroin by opioid agonist or antagonist
	Craving for heroin is driven in part by a long-term abstinence syndrome that is a manifestation of innate or drug-induced biochemical abnormalities	Prevention of abstinence syndrome with methadone or other opioid agonist

From: *Journal of Psychoactive Drugs*, Vol. 23(2), April - June 1991
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shift in thinking regarding treatment modalities?

RAWSON: Early-on there was only one definition of success: the patient had to stop taking all drugs and get totally sober and stay sober for the rest of his life. We know now that addiction is a chronic, relapsing disorder. We know also that the longer you can retain patients in treatment, the longer they are going to live and the better the quality of their lives. As the treatment community becomes more aware of that, they are going to be responsive to understanding why different modalities may be useful for different kinds of patients.

A.T.F.: What is your approach at the Matrix Institute on Addictions?

RAWSON: We try to use a full range of all available treatment modalities: we use methadone for detoxification and maintenance, and we have structured outpatient treatment. Our medical director, Dr. Walter Ling, is currently doing a number of studies with buprenorphine, so we are able to offer patients participation in some research trials, and we've done some work with LAAM. We do refer patients to 28-day programs if they have financial resources and if they appear to be people who can benefit from that approach, and we have made use of the network of therapeutic communities in Los Angeles.

I do think that the treatment community can be responsive if they are given enough information and given a rationale for why different modalities may be useful. It's just that there has been precious little good quality information disseminated to many of the line level counseling and medical staff that are in different treatment centers.

A.T.F.: Are there any new professional education programs that might be of interest to our readers?

RAWSON: We recently completed a project for the State of

California Office of Drug and Alcohol Program called "The Treatment of Opiate Addiction Using Methadone: A Counselor Manual." They were interested in creating a manual for training counselors who work in methadone programs and to provide techniques that could improve the quality of support services.

It's used in a setting where a clinic manager or a senior therapist coordinates the training with the manual, and there is a separate guidebook to assist the trainer. Then, the manual is designed to be an active document that counselors use on a daily basis. It's filled with forms and hand-outs, and patient guides, and some sample treatment plans and sample needs assessment forms.

A.T.F.: Is this available outside of California, and can our readers contact you for more information?

RAWSON: Yes, they can contact us directly. The State of California is currently giving the final approval to disseminate the Manual. Also, the Office of Treatment Improvement (OTI) in Washington, D.C. has expressed an interest in disseminating the manual through their agency and we'll be getting some word on what the plan for that is in the near future.

A.T.F.

OTI Now "CSAT"

As part of ADAMHA's recent reorganization into the Substance Abuse and Mental Health Services Administration (SAMHSA), programs launched by the Office of Treatment Improvement will now be handled by the Center for Substance Abuse Treatment (CSAT). This is one of three Centers which make up the newly formed SAMHSA.

Unabridged Interviews Available

Interviews appearing in A.T. Forum are, of necessity, greatly condensed versions of the actual transcripts. More complete versions providing full discussions of the topics are available. Just check off the appropriate box on the feedback card in this issue and mail in.

Second Methadone Symposium Scheduled

Due to the overwhelming response to the A.T. Forum Methadone Symposium in Chicago, another is being planned for San Francisco in March. Details will follow in future issues of A.T.F.

More Info...

- For a free reprint of the Rawson and Ling article, complete and send in the feedback card in this issue of *A.T. Forum*.
- For the complete back issue of the *Journal of Psychoactive Drugs*, 23 (2), April-June 1991, contact the publication at: Haight-Ashbury Publications, 409 Clayton Street, 2nd Floor, San Francisco, CA 94117 (415/565-1904). This special theme issue, entitled "Opioid Dependence and Methadone Maintenance Treatment," is a valuable reference for treatment professionals. The cost is \$30 + \$3.50 (S/H); California residents add \$2.55 tax.
- For more information about "The Treatment of Opiate Addiction Using Methadone: A Counselor Manual," Dr. Rawson may be contacted at 213/655-4518.

Methadone Myths

Clearing Up Some of the Myth-Understandings



Myths communicate experiences, and while they sometimes contain a grain of truth, more often they reflect misunderstandings — or, “myth-understandings” — developed over time. Methadone maintenance treatment has not escaped such false stereotypes and misconceptions.

A.T. Forum spoke with Joan Ellen Zweben, Ph.D. who has written several articles on this subject. She is Executive Director, The 14th Street Clinic and the Medical Group and East Bay Community Recovery Project, Oakland, California.

A.T. Forum: Could you describe a few methadone myths that actually exist among professionals working in clinics.

JOAN ELLEN ZWEBEN, Ph.D.: One is the stereotype or myth that people on methadone are high. The belief is that because it is a narcotic replacement, people must be getting high, and many people, including profession-

als in the clinics, don't understand that the whole reason we use it is because you can achieve a steady blood level that lets people function *without* the roller coaster effect, the up and down, heroin produces.

There is a myth that you can't do psychotherapy with people on methadone. It simply isn't true! Some methadone patients are in touch with their feelings and others aren't, and it's partly a matter of their character structure and partly a matter of their response to the drug.

Another myth is that methadone doesn't work because people don't do well when they get off of it. If you think about the diabetic, you don't judge the success of insulin by how well people do if they stop taking it.

A.T.F.: In one of your articles you mentioned a researcher who questioned the validity of judging the effectiveness of methadone treatment by studying former patients no longer receiving it. You said, “He likened this to gauging the effectiveness of birth control pills by counting the number of pregnancies that occur after administration is discontinued.”

ZWEBEN: I love that quote. It goes back to people's difficulty in accepting that some people need the drug replacement offered by Methadone on an ongoing basis. What we need to stress is lifestyle changes and recovery, not whether they need to continue on medication.

A.T.F.: Don't some people believe that the higher the methadone dose the harder it is for the patient to eventually quit the drug?

ZWEBEN: There is no documentation that is correct. But many people act like it's true. The patients believe, “I've got to keep my dose down so I can go off some day.” The treatment providers hold the doses down artificially because they think that getting off is a success criteria. Some people can quit methadone, and we should help them as much as we can. But others will not be able to function productively if they try to detox, and we should not harass them.

ADA Activated

Methadone Patients Still Face Dilemma

Title I, the employment provision of the Americans with Disabilities Act, makes it unlawful to discriminate against any qualified person with a disability (including those with a past history of drug or alcohol abuse). It went into effect on July 26, 1992 and now includes all firms with 25 or more employees. The Act extends the protections against discrimination provided in the Federal Rehabilitation Act of 1973 to all employers, not just those which receive federal contracts or grants.

According to Paul Samuels of the Legal Action Center in New York City, “Under the ADA and Rehabilitation Act, it is illegal for an employer to refuse to hire or to fire someone because he is in a methadone program. If, however, he relapses and starts using illegal drugs again, the employer could take action against him.”

The ADA states that employers cannot ask an applicant if he has a disability, nor can they require a medical examination to determine if a disability exists. However, drug testing can be done at any time, since it is not considered a medical examination. This creates a dilemma for individuals involved in methadone maintenance treatment programs. They must decide whether to voluntarily disclose their involvement in a methadone program or risk discovery of their therapeutic methadone use. Either decision could have far reaching consequences.

So, what is the best course of action for individuals regarding disclosure of their involvement in a methadone maintenance program? Ellen Weber, who is Legislative Counsel with the Legal Action Center in Washington, D.C. and was involved in drafting the ADA recommends, “The best thing to do is to be honest if asked, indicate (to the employer) they are aware that their condition is protected and that any information that is gathered is not to be used contrary to the ADA. If they think they are being discriminated against, they should take the employer to task.”

Ms. Weber also stated that qualified individuals who are involved in methadone maintenance programs should be aware that they can not be discriminated against regarding safety-related jobs. “Some employers don't understand how methadone works and therefore will impose some standards that will eliminate people from certain safety-related jobs. The Act will not permit that.” However, there are still grey areas of the Act that must be clarified over time.

"Adequate Dose" continued from Back Page

services which can have a tremendous influence on the outcome of treatment, making the case for high quality care, as well as increased availability of care.

A.T.F.: You've pointed out that the milligrams of methadone a patient consumes does not always correlate with the serum levels of the medication.

PAYTE: Yes, I'd like to stress the need for an increased reliance on blood plasma levels, not for all patients, but for those that are having difficulty in stabilizing or having unexpected problems with doses of methadone. It provides an objective means of determining what patients really need. I have a patient, for example, on 400 mg of methadone a day, 100 mg every six hours. I would never have dreamed of giving such a large dosage without the blood levels.

A.T.F.: What was it about him that required such a large dose?

PAYTE: He's on a medication called carbamazepine for a seizure disorder. He was taking 800 mg of carbamazepine and 180 mg of methadone daily. We did methadone blood plasma levels and at three hours after his dose they were found to be 118 nanograms, which is well below any therapeutic level. At 24 hours, there wasn't even a detectable amount. Subsequently, this patient's dose was increased gradually and split to where he was getting 100 mg four times a day and was then able to do quite well.

A.T.F.: So, without doing those blood plasma level tests you never would have thought of going up that high?

PAYTE: I was nervous about giving this patient 180 mg, and then when we got the blood levels back, 180 was not even touching him! It might just take a little bit of the withdrawal away for three or four hours. The interesting thing is that if he were to inject heroin he would get a full effect, but on oral methadone, because of the passage through the liver, he'd get almost no effect.

A.T.F.: You've written that methadone maintenance should be continued as long as desired by the patient. This implies that it might be a lifelong treatment situation.

PAYTE: "Indefinite" is the preferred term, rather than lifelong. There's a lot of thinking going on now that an indeterminate length of treatment may be

appropriate. This has been supported by studies showing that even in patients that are doing reasonably well, the number of people who return to IV drug use after withdrawing from methadone is still disturbingly high, in the neighborhood of 80% within a short period of time. That, coupled with the fact that, after nearly 30 years of study, long-term methadone treatment has not been found to be dangerous or toxic supports the concept of indefinite maintenance. **A.T.F.**

"Rocky Road" continued from Page 1

\$70 or \$80.

- **"Methadone funds cut"** — San Francisco, CA [*Santa Rosa Press Democrat*, May 17, 1992] — It was announced that a grant from the federal government to Bay Area Addiction Research and Treatment providing free methadone treatment for 381 patients would run out at the end of June. Clients could choose to pay \$225 a month to continue in the treatment program or go through withdrawal.
- **"Clinic Fires Ire: Methadone Program Concessions Made"** — New York, NY [*The Westsider*, July 16, 1992] — The relocation of a treatment center has residents upset in Morningside Heights. They claim that the relocation site is already filled with social service programs, adding to the commercial, residential and foot traffic. A member of the coalition opposing the clinic stated, "We're not NIMBY, we're SMIMBY - Why So Many In My Backyard?" [Could SMIMBY be a new complaint of the future in some areas? - ed]
- **"Methadone Clinics Won't Just Hand Out Doses, officials say"** — Birmingham, AL [*Birmingham News*, July 1, 1992] — New regulations by Alabama officials are the first steps towards increasing control over methadone clinics. The regulations seek to ensure that clinics provide treatment counseling along with dispensing methadone. The substance abuse director for the state mental health agency says there is a concern that with the spread of clinics clients may travel from one clinic to another for multiple methadone doses, known as "double-dipping." **A.T.F.**

"State ... Guidelines" Now Available

First introduced in early November, 1992 at the American Methadone Treatment Association conference in Florida, the "State Methadone Maintenance Treatment Guidelines" manual is available to interested professionals by calling the National Clearinghouse for Alcohol & Drug Information (NCADI) at 301/468-2600.

Could SMIMBY (why So Many In My Backyard) be a complaint of the future in some areas?

J. Thomas Payte, M.D. "Adequate" Methadone Dose?



A.T. Forum interviewed J. Thomas Payte, M.D., Chairman of the ASAM (American Society of Addiction Medicine) Committee

on Methadone Treatment. He, along with Elizabeth Khuri, M.D., is author of a chapter entitled "Principles of Determination of Methadone Dose in Methadone Maintenance Treatment" to be published by the Office of Treatment Improvement in their new manual, State Methadone Maintenance Treatment Guidelines.

A.T. Forum: What are your concerns regarding current methadone maintenance treatment approaches?

J. THOMAS PAYTE, M.D.: Of major concern to me has been the long-standing debate between high [methadone] dose philosophies and low dose philosophies, with little consideration for the clinical and laboratory evidence that forms the basis for dose determination. One of our goals in writing the chapter [mentioned above] was to emphasize individually determined adequate doses, which may vary widely among individuals.

adding very quickly that many patients will need considerably less, and there are going to be some that need considerably more.

John Ball and his colleagues have demonstrated an inverse relationship between recent heroin use and methadone dose. [See Figure 1.] This supports the notion that lower doses are not as effective as higher or adequate doses in facilitating abstinence.

Another study [Capehorn and Bell] demonstrated the importance of dose in the retention of patients in methadone treatment. [See Figure 2.] Patients at 80 mg or more were twice as likely to remain in treatment compared to those taking 60 to 79 mg. And those in the later group were twice as likely to stay in treatment as those receiving less than 60 mg.

Fig. 2

Methadone Dose Range	Relative Risk of Leaving Treatment
Less than 60 mg	100 (baseline)
60-79 mg	47
80+ mg	21

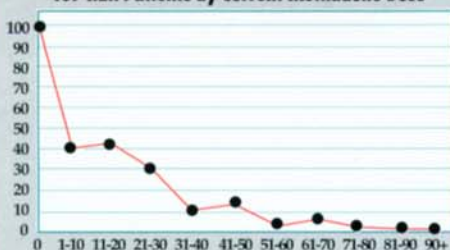
From: Capehorn, J.R.M. and Bell, J. Methadone dosage and retention of patients in maintenance treatment. The Medical Journal of Australia Vol. 154:195-199, 1991

While we stress the importance of adequacy of dose in patient retention and in effectiveness of treatment, we certainly don't want to take away from the importance counseling and other

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Fig. 1

Heroin Use in Past 30 Days
407 MM Patients by Current Methadone Dose



From: Ball, J.C. and Ross, A. The Effectiveness of Methadone Maintenance Treatment, New York; Springer-Verlag; p. 248, 1991.

A.T.F.: The methadone dose you've recommended for most patients is about 80 mg plus or minus 20 mg. Is this correct?

PAYTE: Actually, we've changed that a little bit to coincide with the original recommendations of Dole, Nyswander and Kreek of 80 mg to 120 mg, but

ADDICTION TREATMENT

Forum

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