

FORUM

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Mandatory QTc Screening for Methadone Patients— OTPs Respond to Published Guidelines

Health professionals and government agencies have raised concerns about methadone's potential to produce QT prolongation, with or without the arrhythmia known as torsade de pointes (TdP), in patients in Opioid Treatment Programs (OTPs) and patients prescribed methadone for pain.

This possible risk recently led five clinicians to publish guidelines in the online *Annals of Internal Medicine*, calling for mandatory QTc screening by electrocardiogram (ECG) for all OTP patients, before starting methadone maintenance treatment, and periodically thereafter. Revisions of the *Annals* article subsequently appeared—then disappeared. A final version and related editorial were published in the March 17 print edition.

Many OTP clinicians share the authors' concerns, but advocate screening or referral for a careful workup by a specialist after evaluation and assessment of risk. OTPs maintain that the costs and logistics of mandatory ECGs will deter some patients from entering potentially life-saving methadone therapy.

Earlier Methadone-Related Cardiac Concerns

LAAM. Arrhythmia concerns surfaced in 2001, linked with levomethadyl acetate (LAAM), a synthetic opioid no longer manufactured. The Food and Drug Administration (FDA) required that a manufacturer's black box warning be added to the package insert (PI) concerning the potential of LAAM to cause arrhythmias, and recommended ECGs before starting Medication-Assisted Treatment (MAT) with LAAM, and during LAAM stabilization.



The 2006 FDA Methadone Advisory. In 2006, the FDA issued a methadone advisory in response to reports of life-threatening events and deaths in some patients receiving methadone treatment. The events comprised a slowing or cessation of breathing, QT prolongation, and TdP, and led to a PI black box warning.

CSAT Actions. In July 2007, the Center for Substance Abuse (CSAT) of the Substance Abuse and Mental Health Service Administration (SAMHSA) convened a meeting, Methadone Mortality—A Reassessment. Recommendations that emerged included appointing an expert panel to draft guidelines for screening methadone patients for cardiac arrhythmias. On July 15, 2008, CSAT circulated among a select group a review draft (stamped "Not for Reproduction or Redistribution") of the CSAT Draft Screening Guidelines.

Unauthorized Guidelines Published in *Annals of Internal Medicine*

Five of the CSAT Expert Panel participants released the field review document in the online *Annals of Internal Medicine* before review and feedback from the field, the process CSAT has followed in all previous consensus publications. (CSAT sent the guidelines out for field review in January 2009.)

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In This Issue

Opioids + Benzodiazepines = Danger

What do oxycodone, hydrocodone, diazepam, alprazolam, temazepam, and doxylamine have in common? These drugs were found in Heath Ledger's body when he died in January 2008—two prescription opioids, three prescription benzodiazepines, and an over-the-counter sleep-aid. All six drugs can suppress the central nervous system and cause respiratory depression. According to the New York City medical examiner, their cumulative effects killed the 28-year-old actor.

Heath Ledger's death brought to mind the death of Anna Nicole Smith, in February 2007, with nine drugs in her system—three opioids (morphine, hydromorphone, and methadone) and two benzodiazepines (flurazepam and diazepam). Why would people do this to themselves?

Our feature article, "The Dangers of Benzodiazepine Abuse in Medication-Assisted Treatment (MAT)," provides an overview of benzodiazepines—what they are, why some patients in MAT abuse them, and why they are so dangerous when combined with methadone or alcohol. We also cover the impact of benzodiazepine abuse on the clinical course and outcomes in MAT, and the implications for patients and staff in Opioid Treatment Programs (OTPs) (*see article on page 6*).

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Also in This Issue

Last December, five members of a Center for Substance Abuse Treatment (CSAT) panel on the cardiac effects of methadone acted hastily in publishing, online, and later in the March 17 print edition of the *Annals of Internal Medicine*, a controversial article, "Clinical Guidelines on QTc Screening in Methadone Treatment"—even though the document is still out for CSAT field review. Our cover story recapitulates the developments to date, the reactions from OTPs, and a policy and guidance statement from the American Association for the Treatment of Opioid Dependence (AATOD).

On a positive note, exciting news is emerging from New York. When New York State OASAS Commissioner Karen M. Carpenter-Palumbo took office, she realized that the methadone treatment system was not working. In an interview with *Addiction Treatment Forum*, the commissioner shared her plans to transform OTPs into Addiction Recovery Centers (*see article on page 4*).

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The guidelines are "beyond the ability of most methadone providers to implement," and are based on a disconnect with "the reality of clinical practice."

Annals Version 1. The CSAT Consensus Guidelines were first published December 1, 2008, in the Clinical Guidelines section of the online *Annals of Internal Medicine*. (Print publication was scheduled for January 2, 2009.) The article was titled "QTc Interval Screening in Methadone Treatment: The CSAT Consensus Guidelines." The title indicated that the authors were writing on behalf of the CSAT Expert Panel—when in fact at least two panel members were not even aware that the article was being developed.

The published QTc screening guidelines included:

- Inform patients about the risk of arrhythmia when starting methadone treatment.
- Ask patients about any history of structural heart disease, arrhythmia, and syncope.
- Obtain ECGs for *all* patients; measure the QTc interval pretreatment, again within 30 days, then annually; additionally, if methadone dosage > 100 mg/d, or if syncope or seizures develop.
- If the QTc interval is > 450 ms but < 500 ms, discuss the potential risks and benefits with patients, and monitor them more often; if the QTc interval is > 500 ms, consider: discontinuing or lowering the dose; eliminating contributing factors, such as drugs that promote hypokalemia; or using alternative therapy.
- Be aware of interactions between methadone and other drugs that prolong the QT interval or slow methadone elimination.

Several days after it appeared online, the *Annals* article was pulled, at CSAT's request. It was also removed from the January print edition.

Annals Versions 2 and 3. On January 20, the article resurfaced on the *Annals* website, with print publication now scheduled for March 17. Missing from the title were “The CSAT Consensus Guidelines,” and the authorship designation “for the Center for Substance Abuse Treatment Cardiac Expert Panel”—thus making the panel independent from the article’s authors. But the article still listed the Expert Panel members by name, and still cited CSAT as the panel’s convener and as a funding source.

The third version deleted, at their request, the names of two CSAT Contributing Panel members who had not been asked for permission to be listed.

Editorial Response. In early February a related editorial appeared on the *Annals* website. The editorial, published in the March *Annals* print edition, criticized the panel’s lack of scientific basis for its recommendations, lack of explanations for its decisions, and lack of a literature review to plan the data-gathering process.

Detailing the substantial harm routine ECG screening could cause, the editorial commented, “For the typical person who begins methadone treatment, the risk for death from torsade de pointes is likely to be substantially lower than that from competing causes of mortality associated with untreated opioid addiction.” Thus, the title of the editorial: “First Do No Harm...Reduction?”

OTP Clinicians Respond to Screening Guidelines

In January, shortly after the first online draft was published, Mark W. Parrino, MPA, president of the American Association for the Treatment of Opioid Dependence (AATOD), fielded questions and concerns about the published guidelines. Some practitioners thought the recommendations were final and required implementation. Others asked if CSAT had approved the guidelines, and why they hadn’t gone through normal federal channels, instead of being published first in a peer-reviewed journal.

In letters and Web postings, clinicians strongly disagreed with the proposed guidelines—calling them unnecessary, costly, and impractical; based on a disconnect with “the reality of clinical practice,” “beyond the ability of most methadone providers to implement,” and no substitute for the provider-patient relationship—“Serial [ECGs] cannot replace an informed patient.” One reader suggested the authors were “inadequate and biased.” Some readers mentioned practical problems: “Medi-Cal has told us...they won’t authorize serial screening EKGs.” Several cited the rarity of methadone-associated problems: from 1969 to 2002 only “43 cases of methadone-associated TdP and 16 cases of QTc prolongation [were] reported [to the FDA’s MedWatch Program].”

AATOD Issues Policy and Guidance Statement

After substantial field review, AATOD has released guidelines that differ substantially from those published in the *Annals of Internal Medicine*:

“Consider a baseline and follow-up 12-lead ECG for patients with a history of arrhythmia, prolonged QTc, a family history of premature death, and/or other significant arrhythmia risk factors on admission or for suspected arrhythmia risks in ongoing methadone maintained patients.”

“Refer for cardiac consultation cases of cardiac conditions affecting heart rhythm, unexplained syncope, or seizures or a significant increase in QTc from baseline.”

The guidelines also recommend that OTPs develop a Comprehensive Cardiac Arrhythmia Risk Management Plan that includes “the type, threshold and frequency [of arrhythmias] for screening and monitoring.”

AATOD believes that these safeguards, individualized induction practices, and informed and appropriate monitoring and follow-up offer the best protection for patient safety. AATOD further believes, “Prospective clinical trials are needed before routine ECG screening can be endorsed.”

For the complete AATOD recommendations, visit <http://www.aatod.org/qt.html>.

...the panel had identified from previous studies a prevalence rate of about two percent in OTP patients with QTc intervals > 500 ms. They projected, “approximately 5,000 of the 250,000 patients in opioid treatment programs would exceed this threshold and constitute the principal target for risk-reduction interventions.”

Weighing the Risks

Certain methadone patients—especially those who are on high doses or taking other drugs that impact QTc levels—face some risks when taking methadone. But if mandatory ECG screening is established, some OTPs will not have the resources to comply. Already some programs have considered limiting methadone doses to 100 mg/day. Some programs will pass along the compliance costs, either by raising fees or by requiring patients to obtain an ECG from a primary physician and return the results to the OTP. Insurance and malpractice costs will rise. There is a need to find some way of balancing the risks of TdP and enabling patients to access MAT without creating additional barriers and increasing the stigma associated with methadone maintenance treatment.

The *Annals of Internal Medicine* article, editorial, and reader responses can be accessed at: <http://www.annals.org>.



ECG screening will be a featured topic at the AATOD Conference, April 25 through 29 in New York City. A discussion, “What to Do About QT: Assessing and Reducing Cardiac Risk in the OTP,” will be held Tuesday, April 28, from 10:30 to noon. Speakers include three authors of the *Annals* article. Audience comments will be incorporated into CSAT’s field review process.

Transforming New York's OTPs into Addiction Recovery Centers

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An Interview with OASAS Commissioner Karen M. Carpenter-Palumbo



Developed in New York in the 1960s, through the pioneering work of doctors. Vincent Dole and Marie Nyswander, methadone maintenance is the most thoroughly studied evidence-based practice for treating substance-use disorders.

Yet this innovative modality has not kept pace with the multiple challenges posed by patients needing opioid treatment: multiple federal and state regulatory oversight agencies; clinical services focused on opioid use and on over-reliance on medication management as the primary intervention; strained relations in many Opioid Treatment Program (OTP) neighborhoods; and stigmatized perceptions of the methadone patient—in some cases extending to those working in the field.

Under the leadership of Commissioner Karen M. Carpenter-Palumbo of the Office of Alcoholism and Substance Abuse Services (OASAS), New York State has committed itself to transforming this \$248-million industry serving over 40,000 patients per day into a patient-centered, comprehensive service consistent with the recovery orientation espoused by the state.

Acknowledging that methadone is simply a medication, albeit an extremely effective one, Commissioner Carpenter-Palumbo appointed a time-limited task force, the Methadone Transformation Advisory Group (MTAG), to transform OTPs into addiction-recovery centers. Her vision is to fully integrate OTPs, over time, into New York's addiction-treatment system.

Addiction Treatment Forum discussed the challenges facing MTAG, and the agency's activities and goals, with Commissioner Carpenter-Palumbo. Also present were MTAG Co-chairs, Frank McCorry, PhD, director of the New York State Office of Alcoholism and Substance Abuse Services (OASAS) in New York City; and Ira J. Marion, MA, director of government relations, Department of Psychiatry and Behavioral Sciences, Albert Einstein College of Medicine.

Commissioner Carpenter-Palumbo came into office with a reform agenda, intent on revitalizing OASAS. After meeting with the

Committee of Methadone Program Administrators, Inc. (COMPA), the New York State OTP coalition, and leaders in the treatment field, the commissioner visited OTPs across the state to learn what was and wasn't working from the perspectives of the front-line staff and the patients themselves. "I stood in line with patients receiving their medication at a clinic one Saturday in New York City," she told *AT Forum*. "I talked with them to see how the system was working. I found that some clinics offer a range of services and run like clockwork. But others operate rather rigidly, and seem to be only dispensing methadone."

What Commissioner Carpenter-Palumbo learned is the impetus for major changes in the way New York State views OTPs.

Currently, New York State has a stand-alone license for methadone treatment, with its own regulations, set-asides, and oversight system. This isolates OTPs and a valuable medication from treatment providers and clinicians. Part of her vision, the commissioner told *AT Forum*, is to establish methadone treatment as "an important stabilizing and credible form of therapy, not as a stepchild or isolated treatment network, but as part of a chronic-health, recovery-oriented system of care, fully integrated into the OASAS continuum.

"We realized we'd need to make all types of treatment available to all people, regardless of what door they walk in—the methadone door, the outpatient-clinic door, or the hospital door. We'd have to incorporate everything into one system of care. So that's how it all began."

A visionary with the drive to see things through, Commissioner Carpenter-Palumbo "intends to merge the stand-alone regulations for methadone treatment with the regulations for all other outpatient treatment programs, creating a single set of medically supervised outpatient regulations," Frank McCorry said. "As the commissioner has envisioned it, methadone treatment will no longer exist as a separate type of therapy in New York. It will be an integral part of the OASAS outpatient system of care."

MTAG Implementation Workgroups

1. Introduce into OTPs ambulatory detoxification for uncomplicated opioid dependence
2. Integrate buprenorphine into OTPs as another medication-assisted treatment
3. Implement clinical phases of care
4. Initiate interim maintenance where waiting lists exist in upstate New York
5. Expand methadone medical maintenance
6. Implement proactive community relations, so that programs using methadone are an integral part of their communities
7. Train patients who have the aptitude and desire to become counselors
8. Develop a single ambulatory system of care



To that end, MTAG is currently running eight implementation workgroups to begin transforming the entire system (see *Sidebar*).

“I insisted that any task force or workgroup be co-chaired by an OASAS leader and by a leader from the provider or consumer community—to make sure we’re working cooperatively, and in partnership, toward the same goals,” Commissioner Carpenter-Palumbo said.

“We have good buy-in,” Ira Marion added. “The Commissioner was very careful right from the planning stages to involve providers from all treatment modalities. We have people from OTPs, therapeutic communities, from outpatient, private for-profit and private nonprofit, and from consumer coalitions. Now, as we begin implementation, each working group comprises the people who are going to implement the strategy and make sure that it works.”

Ambulatory Detoxification. Currently the state spends hundreds of millions of dollars every year on inpatient care for opioid-dependent people admitted for detoxification. MTAG plans to work with hospitals and other facilities to see that, in uncomplicated cases, patients will be referred to OTPs for ambulatory detoxification. There, patients will receive individualized assessment, then referral to the appropriate level of care, which may be an OTP or a longer-term treatment modality.

“In my vision, when someone walks into any of our facilities hoping to break their cycle of addiction, we can and will help them. We will describe the types of treatment available, and we’ll encourage prevention, treatment, and recovery, at a level of care that will meet their needs—one door to recovery; one healthier New York.”
– Commissioner Karen M. Carpenter-Palumbo

Introducing Buprenorphine into OTPs. To date, buprenorphine has not been widely adopted by OTPs in New York. CSAT is expected to clarify federal regulations to allow its use in New York’s OTPs. Offering alternative medications will diversify the OTP clinical-service delivery model for individual patients’ needs.

Developing Clinical Phases of Care. “Several MTAG workgroups focused on the clinical phases of care, based on CSAT TIP 43. These phases identify treatment along a continuum, from interim maintenance (when comprehensive treatment is unavailable) to acute, rehabilitative, and then supportive care; medical maintenance or tapering; and continuing care,” Frank McCorry told *AT Forum*. “We’re training staff to see patients in terms of these clinical phases, rather than as ‘one size fits all,’ so they can better respond to individual patients’ needs.”

Training Patients to Become Counselors. “When patients see their counselor successful in methadone treatment, working in a treatment program, it helps dispel the fear of exposing themselves as methadone patients, and sends a message that success and recovery are

possible,” Ira Marion said. “We need patient-counselors other patients can look up to, who are unafraid to say, ‘I’m in long-term recovery, through medication-assisted treatment.’”

Improving Community Relations. Oversized OTPs serving hundreds of patients aren’t welcome in many communities; understandably so. The current Medicaid reimbursement system of weekly fees has created a “siloeed” (isolated) approach and ever-larger OTP facilities. Large, isolated facilities serving only methadone patients have promoted the stigma that is attached to OTPs, and has even spread to mainstream addiction care.

All of this is about to change.

One Ambulatory System of Care. New York will become the first state to be reimbursed for outpatient mental health and addiction-treatment services through a prospective payment system known as Ambulatory Patient Groups (APGs). Developed as a payment system for Medicare, the APG system is based on codes similar to Medicare’s diagnosis-related group (DRG) codes for inpatient care.

Under the APG system, reimbursement for methadone programs will be the same as reimbursement for all other outpatient addiction programs. Over time, methadone treatment will be available at existing outpatient clinics, and OTPs will offer all addiction-recovery services. OTPs will become part of a single, chronic-illness system of care—fulfilling Commissioner Carpenter-Palumbo’s vision of providing care to everyone who enters the door of any addiction treatment facility in New York State.

These two major changes—merging OTPs into a single system of care, and allowing all clinics to provide medication-assisted treatment—will greatly improve community relations. All clinics will offer a variety of treatment services. OTPs won’t be large “silos” for medication. Neighborhood residents won’t know what kind of help people going to the clinic are seeking.

“Downsized sites will attract patients in the community who have other addiction issues,” Ira Marion pointed out. “People who need medication-assisted treatment will look for the place where they’ll get the best care. Even a 16-year-old, hopefully with a parent, should be able to walk in for assessment and referral.”

“Instead of methadone clinics, there will be clinics for treating the chronic illnesses of addiction,” Commissioner Carpenter-Palumbo told *AT Forum*. “People could be addicted to prescription drugs or to heroin. They could be the residents’ neighbors, husbands, or grandparents. This is the challenge that New York has set as a long-term goal of MTAG.”

“In my vision, when someone walks into any of our facilities hoping to break their cycle of addiction, we can and will help them. We will describe the types of treatment available, and we’ll encourage prevention, treatment, and recovery, at a level of care that will meet their needs—one door to recovery; one healthier New York.”

Source: Center for Substance Abuse Treatment (CSAT). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 06-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005, reprinted 2006. <http://download.ncadi.samhsa.gov/Preview/pdfs/bkd524.pdf>

The Dangers of Benzodiazepine Abuse During MAT

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Benzodiazepine abuse and dependence are common among patients entering Medication-Assisted Treatment (MAT). Continued abuse during methadone maintenance therapy is dangerous for patients, and presents special challenges to the staff of Opioid Treatment Programs (OTPs). Extra time and resources are usually necessary to help patients safely overcome this serious barrier to recovery, but with appropriate care, OTPs can help these patients.

What Are Benzodiazepines?

Benzodiazepines, a class of Schedule IV drugs, are among the most commonly prescribed medications in the U.S. They act by depressing the central nervous system, and are prescribed to treat conditions such as depression, anxiety, and sleep disorders. Taken as prescribed, they have a good safety profile.

The five most commonly prescribed—and the most commonly abused—benzodiazepines are Xanax (alprazolam), Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam), and Restoril (temazepam). Their duration of action ranges from a few hours to more than one day.

Why Patients Abuse Benzodiazepines

OTP patients who abuse benzodiazepines typically take them within an hour of their methadone dose. They report that mixing the two drugs this way—known on the street as “boosting”—increases the euphoric feeling. As blood levels of methadone peak, the benzodiazepine dose reaches its maximum effect. Although the two drugs work separately, together they create the illusion of “boosting” methadone’s opioid effect.

Also, patients may abuse benzodiazepines to self-medicate psychological stress, and some believe they help diminish opioid withdrawal symptoms.

Side Effects and Tolerance

Benzodiazepines have depressive effects on the central nervous system, sometimes serious ones, especially in the high doses typically taken by patients who abuse these drugs. They can decrease motor coordination and increase reaction time. Slurred speech, staggering, respiratory depression, and memory impairment or loss are common symptoms of abuse. The memory impairment or loss is not permanent; it spans the time the patient is under the drug’s influence. Other side effects include restlessness, delirium, aggression, hallucinations, and paranoia. Side effects are especially common in patients who have not developed tolerance.

Tolerance can occur after long-term abuse, with larger doses needed to reach the desired effect. Benzodiazepines with shorter half-lives tend to produce tolerance and addiction more quickly than those with longer half-lives. Withdrawal symptoms can occur between doses of short-acting ones, causing craving for the next dose. After three months or more, patients may develop physiological dependence—even if taking the drug in prescribed doses.



The severity of withdrawal symptoms depends on the benzodiazepine used, the dose, and the duration of use. Common withdrawal symptoms include rebound anxiety and agitation, insomnia, tension, sweating, and sensory and perceptual distortions. Serious withdrawal reactions include seizures, convulsions, attempted suicide, and suicide.

The Dangers of Combining Benzodiazepines with Methadone or Alcohol

Respiratory depression – During methadone induction or dosage increases, even patients who have acquired tolerance for the depressant effects of opioids may develop respiratory depression. Because benzodiazepines also depress respiration, the two drugs together can cause the patient to stop breathing—even when the same dose of either drug alone might not be lethal. Adding alcohol, another respiratory depressant, further increases the danger. Because patients who abuse benzodiazepines may be unable to make prudent decisions about safety, they may be especially susceptible to alcohol abuse.

Increased risk for overdose and mortality – In studying the records of 176 methadone-related deaths in Kentucky, Shields and coworkers found that methadone was the only drug identified in the blood at autopsy in just a few cases (6 percent). A benzodiazepine with methadone was present in about one-third of the cases. Blood levels of methadone were usually lower if both drugs were identified than if only methadone was present—underscoring the potentially deadly effect of combining the two drugs.

Sedative effect – Benzodiazepines can impair a patient’s ability to drive a car, especially when taken with alcohol or other sedating medications.

The sedative effects increase reaction time and interfere with motor coordination, possibly causing accidental injury or death in traffic accidents or other incidents. OTP patients must be thoroughly educated about the dangers of driving a car while under the influence of benzodiazepines, other sedatives, alcohol, or a combination.

Characteristics of Benzodiazepine Abusers in OTPs

OTP patients who abuse benzodiazepines are more likely than non-abusers to be unemployed or engaged in criminal activity, and to have a history of more-severe drug abuse. They also are more prone to



Benzodiazepines can impair a patient’s ability to drive a car, especially when the drug is combined with alcohol or other sedating medications.

engage in risk-taking behaviors linked with exposure to human immunodeficiency virus (HIV) and hepatitis C virus. In addition, they are more likely than non-abusers to be under psychological stress. In a recent study by Brands and associates, 70 percent of those who regularly abused benzodiazepines reported thoughts of suicide, and 53 percent had attempted suicide. Those who habitually used benzodiazepines also used illicit opioids more often.

Brands' group also found that women are more likely than men to abuse benzodiazepines. This may be because women have a greater incidence of psychiatric problems than men, including low self-esteem, depression, anxiety, and suicidal thoughts and attempts.

Impact of Benzodiazepine Abuse on Clinical Course and Outcomes in MAT

Patients who abuse benzodiazepines during methadone maintenance tend to have more-complex clinical problems and a more difficult clinical course than nonusers, Brands' team found. Abuse during methadone maintenance is often linked with a longer history of opioid dependence, more overdose incidents, and a higher likelihood of psychiatric problems. Patients abusing or dependent on benzodiazepines usually need detoxification and intensive treatment interventions to remain safely in MAT.

Although work by others suggests that benzodiazepine use has a negative effect on MAT outcomes, the Brands study found no link to the retention rate in MAT.

Implications for OTP Staff and Patients

Some OTPs do not admit applicants who are abusing benzodiazepines. This is unfortunate, because these people have the greatest need for help. Yet the OTPs' position is understandable, because patients who abuse them are less likely to succeed in MAT.

OTP staff need to be alert to the signs of benzodiazepine abuse. Patients may appear to function normally at the clinic, only to abuse benzodiazepines, or alcohol, or both, later in the day. Some patients who take them immediately before their clinic visit appear normal when arriving at the clinic, only to become high after leaving. If a patient leaves an OTP intoxicated from benzodiazepines, the community is likely to blame methadone, reinforcing the stigma OTPs face.

All OTP staff members need to know the warning signs of excess sedation from combining benzodiazepines with methadone. Visible signs include slurring of speech, and staggering. OTP staff members who are aware that a patient abuses these drugs have a responsibility to do whatever is possible to prevent the patient from driving while sedated.

Routine drug testing is necessary to identify the patients in methadone maintenance who are using benzodiazepines. Patients should be tested for the presence of benzodiazepines and other drugs of abuse before methadone treatment begins. They should also be screened for psychiatric disorders, to determine if psychotherapeutic intervention is required.

When a patient in maintenance treatment develops a condition that is appropriately treated with a benzodiazepine, the prescription should be written either by the OTP physician or by an outside physician who will monitor the patient jointly with the OTP staff.

Patients need to be educated about the consequences of abusing benzodiazepines in MAT. When a patient arrives at the clinic sedated from benzodiazepines, or alcohol, or both, for safety's sake, the clinic medical staff may need to temporarily lower the patient's usual methadone dose, delay or withhold methadone for the day, and limit or eliminate take-home privileges. It would be medically improper and dangerous to give methadone to someone who is under the influence of benzodiazepines.

OTPs should consider special programs for patients who abuse benzodiazepines while under their care. Motivational interviewing, contingency management, and cognitive behavioral treatment are evidence-based practices that have proven effective in reducing their use in MAT patients. Some form of detoxification may also be needed if a patient is physically or psychologically dependent on benzodiazepines.

Sources available online at <http://www.ATForum.com>.

Events to Note

American Psychiatric Association (APA) 162nd Annual Meeting

May 16-21, 2009

San Francisco, California

Contact: www.psych.org

2009 National Association of Addiction Treatment Providers (NAATP) Annual Addiction Treatment Leadership Conference

May 17-20, 2009

West Palm Beach, Florida

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

2009 New England Institute of Addiction Studies

June 1-4, 2009

Bristol, Rhode Island

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

2009 NASADAD/NPT/NTN Annual Meeting

June 3-7, 2009

Syracuse, New York

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

National Association of Drug Court Professionals 15th Annual Training Conference

June 10-13, 2009

Anaheim, California

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

The College on Problems of Drug Dependence (CPDD) Annual Meeting

June 20-25, 2009

Reno, Nevada

Contact: <http://www.cpdd.vcu.edu>

Online Resources

Manuals are available to help OTPs implement evidence-based practices. Two examples focus on other abused substances, but also contain general information that can be applied to benzodiazepines:

The "Matrix Counselor's Treatment Manual," for adults abusing stimulants, is available for free download at: <http://www.kap.samhsa.gov/products/manuals/matrix/pdfs/matrixcounselortreatmentmanual.pdf>.

The "Therapy Manual for Drug Addiction (#1) A Cognitive Behavioral Approach: Treating Cocaine Dependence" is available for free download at: <http://www.drugabuse.gov/pdf/CBT.pdf>.

Overcoming Admission Barriers to MAT

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Researchers interviewed 26 heroin-dependent individuals from the streets of Baltimore, Maryland, to determine why they did not seek Medication-Assisted Treatment (MAT) during the past 12 months. (Almost three out of four had previously pursued treatment.) Their reasons included:

Long Waiting Lists – the inconvenience of contacting Opioid Treatment Programs (OTPs) for progress reports on availability of treatment slots

Apprehension About Long-Term Maintenance – a long commitment, rather than six- or twelve-month treatment

Demands Associated with MAT – required daily methadone dosing, mandatory counseling sessions, frequent urine testing, loss of control to the OTP, and involuntary methadone detoxification if incarcerated

Pharmacological and Physical Issues – misperceptions: methadone therapy substitutes one drug for another; methadone rots your bones and teeth; and methadone withdrawal is worse than heroin withdrawal

Also mentioned were lack of money or insurance, and doubts about the effectiveness of methadone treatment (participants had seen patients purchasing and using other drugs). Some participants did not want to give up the lifestyle of opioid addiction, and probably would not be successful candidates for MAT. Other participants preferred self-medication with street methadone.

Suggestions for OTPs

Lack of treatment slots, money, or insurance may be difficult problems for OTPs to overcome, but participants' responses yield other suggestions for lowering barriers and attracting patients:

1) Provide flexible and individualized services, driven by patient need, and flexible length of treatment; 2) Arrange for rapid access to treatment; 3) During initial screening, point out the advantages of MAT and staffers' expectations for patients; 4) Present evidence-based outcomes about phases of care and duration of treatment, so patients can make informed decisions.

If the clinic has a waiting list: Immediately refer clients to other OTPs, office-based buprenorphine treatment, or an interim-maintenance program. For applicants who are on a waiting list and can be contacted: follow up with weekly phone calls or postcards, and provide a toll-free call-in number with a confidentiality code.

Additional ways to lower barriers include providing flexible dosing hours, to accommodate work schedules or family obligations; and arrange for access to child care, social activities, transportation, and vocational training or employment assistance.

Community- and patient-education programs can help dispel misperceptions about methadone, and street-outreach and harm-reduction programs can be highly successful in lowering barriers and recruiting patients.

Sources available online at <http://www.ATForum.com>.

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