ADDICTION TREATMENT
Forum

A Collaborative Initiative for Patients and Clinical Professionals

Volume 17, #1
Winter 2008

15 years ANNIVERSARY ISSUE
Serving the Addiction Treatment Field

From the Publisher

Serving the Addiction Treatment Community Since 1992

Collaboration has always been a key commitment in our approach to colleagues and readers alike. As publishers, we have found it to be a successful way to generate innovative ideas and to provide meaningful, practical, and effective solutions for health care problems.

An excellent example of this is our publication, *Addiction Treatment Forum*. During the past fifteen years, Covidien Mallinckrodt has consistently supported the addiction treatment community through an educational grant sponsoring this interactive quarterly newsletter. Since 1992, *AT Forum* has continually and successfully reported on the key issues of the day, and provided its readers with insights from the innovative thought leaders in this community.

Now, after publishing 56 issues of *AT Forum*, we have redesigned the newsletter to make it more visually appealing and easier to read. We will strive to diversify our topics, keeping in mind the varied backgrounds of our 11,000-plus readers, among them patients, clinic staff members, researchers, key opinion leaders, and government officials. Of course, we will continue to focus on keeping the articles concise, balanced, and current, to best use your limited time for reading professional literature. As appropriate, longer versions of some articles will be available at our website, www.ATForum.com.

Over the next few issues we will celebrate our 15th anniversary by reflecting on the past 40-plus years of methadone maintenance treatment (MMT), current issues in MMT, and thoughts about the future of MMT as it evolves into broader Opioid Treatment Programs (OTPs). In this issue we've interviewed the renowned MMT and HIV/AIDS pioneer, Beny Primm, MD, for his perspective on MMT, past, and present.

Other articles in this issue include an interview with Catherine H. O'Neill, Esq., from the Legal Action Center in New York, offering useful suggestions for reducing risk in OTPs. Risk management in OTPs has recently emerged as a key issue, in part due to numerous reports of methadone diversion and overdose. This issue also includes highlights from the AATOD (American Association for the Treatment of Opioid Dependence) Conference, "Evidence-Based Principles & Practices: Improving Medication Assisted Treatment." The Conference was held October 20 to 24 in San Diego.

On a final note: After 15 years, Stewart B. Leavitt, MA, PhD, the Editor of *AT Forum*, has decided to pursue other interests. I want to thank him for his major contributions to the addiction treatment community, including his last issue, Methadone Overdose in MMT. We wish him the best in his new endeavors.

We thank you, our readers, for your continued interest in *AT Forum*. As always, your feedback is important to us.

Sue Emerson Publisher
ATForum@ATForum.com

Addiction Treatment Forum
P.O. Box 685; Mundelein, IL 60060
Phone/Fax: 847-392-3937
Internet: http://www.ATForum.com
E-mail: Feedback@ATForum.com

AT Forum is made possible by an unrestricted educational grant from Covidien Mallinckrodt, St. Louis, MO, a manufacturer of methadone & naltrexone.

In This Issue

From the Publisher – 15th Anniversary Issue 1

AATOD Conference Recap . . . 2
2007 Nyswander-Dole "Marie" Award Recipients 3

Events to Note. 2

New Report on Methadone Overdose Deaths. 2

MMT: Past, Current, Future – Part I. 4
MMT History Timeline 4
MMT Pioneer: Beny J. Primm, MD 8

Reducing Risks in OTPs: Planning, Preparing, Preventing 6
FAQ: Methadone and Driving Safety 6

AATOD National Conference Convenes in San Diego

The American Association for the Treatment of Opioid Dependence, Inc. (AATOD) convened its 22nd Annual National Conference at the Sheraton Hotel in San Diego this past October, in the shadow of brush fires fueled by Santa Ana winds. The conference theme was "Evidence-Based Principles & Practices: Improving Medication Assisted Treatment."

Attendance exceeded AATOD expectations: 1160 participants from around the globe, including the U.S., Canada, Mexico, China, and Western and Eastern Europe, traveled to San Diego for the conference.

International Federation Formed

AATOD President Mark W. Parrino, MPA, announced at the pre-conference AATOD Board meeting that this past July, AATOD and international colleagues from Europe and Asia had signed an agreement to unite at the Europad meeting in October in Ljubljana, Slovenia.

The new World Federation for the Treatment of Opioid Dependence will combine AATOD with Europad and other coalitions abroad.

Mr. Parrino predicted that this new federation will have a positive impact in the effort to make medication-assisted treatment available throughout the world, thus helping countless people improve their quality of life. To emphasize his point, Mr. Parrino announced that Mexico had just been approved for admission as the first foreign member of the AATOD Board.

Methadone Mortality

Throughout the conference, concern about deaths involving methadone, prescribed either for pain or for opioid treatment, was on the minds of policy makers, providers, and government officials. It was at the AATOD Open Board Meeting, a tradition of each AATOD Conference, that the issue of methadone deaths was first raised. That meeting became the stage for a frank and passionate discussion of the increase in the methadone mortality rate (see Methadone Overdose Deaths report sidebar below).

The Board accepted policy recommendations from Policy Committee Chair Janice Kauffman, RN, MPH, LADC, CAS, of Massachusetts, that were designed to minimize adverse occurrences during an Opioid Treatment Program (OTP). Ms. Kauffman conceded that some increases in the mortality rate may be related to methadone diversion by clinic patients, but she stressed that in some areas of the U.S., the increases are associated with methadone prescriptions issued by pain specialists and general practitioners who treat patients who have chronic pain.

NASADAD Issues Report on Methadone Overdose Deaths

This past November, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) issued a 23-page report on methadone overdose deaths. This report describes national and state efforts to explore the extent of the problem, the benefits of methadone for addiction treatment and pain management, the risks associated with methadone use, and efforts at a national and state level to better understand the problem and to reduce methadone overdose deaths. After reviewing data on opioid sales, patterns of prescribing and dispensing, and data on drug-associated mortality, National Assessment participants concluded that the available data suggested that methadone tablets and/or diskettes that had become available through channels other than OTPs were most likely the central factor in the recent increases in methadone-associated mortality. The 23-page report can be accessed at http://nasadad.org/resource.php?base_id=1159.

Events to Note

American Counseling Association (ACA) Annual Conference and Exposition
March 26-30, 2008
Honolulu, Hawaii
Contact: 800-347-6647 or http://www.counseling.org/

Society of Behavioral Medicine Annual Meeting & Scientific Sessions
March 26-29, 2008
San Diego, California
Contact: 414-918-3156 or http://www.sbm.org/meeting/2008/

American Society of Addiction Medicine (ASAM) 39th Annual Medical Scientific Conference
April 10-13, 2008
Toronto, Canada
Contact: 301-656-3920 or http://www.asam.org

For additional postings, including international meetings, see: www.ATForum.com.

(To post your announcement in AT Forum *and/or our website, fax the information to: 847-392-3937 or submit it via e-mail to Feedback@ATForum.com*

Throughout the conference, concern about deaths involving methadone, prescribed either for pain or for opioid treatment, was on the minds of policy makers, providers, and government officials.

The Policy Committee's recommendations included:

- Eliminating standardized dosage increases during stabilization
- Using greater vigilance in dispensing take-home medication to unstable patients
- Increasing physician training
- Standardizing reporting of mortality rates

The AATOD Board also moved to help OTPs prevent adverse outcomes of treatment.

In a report to the AATOD Board, H. Westley Clark, MD, JD, MPH, spoke in detail about methadone deaths. Dr. Clark is Director of the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT). Dr. Clark and his staff focused on concerns facing CSAT, and strategies for addressing what he termed a "complex problem." He called for standardized protocols for reporting deaths involving the presence of methadone in the decedent's system, echoed the call for more extensive medical training, and announced that SAMHSA/CSAT will require reporting of deaths by OTPs.

A discussion ensued concerning the increase in treatment programs and the rise in methadone-related mortality rates. Dr. Clark advised that the West Virginia State Government has imposed a moratorium on OTP expansion, and now requires daily visits for all patients who test positive for the presence of drugs. CSAT staff suggested that other states may follow West Virginia's lead.

The CSAT report to the Board became the catalyst for input from members of Helping America Reduce Methadone Deaths (HARMD). Members challenged the mortality rate being reported, and passionately called for increased efforts to prevent diversion and to improve the quality of treatment. (HARMD is a group whose members have lost loved ones in methadone-related deaths.) An emotional and informed discussion followed, involving HARMD, the AATOD Board, CSAT staff, and patient advocates.

Conference Sessions

Before the music began at the AATOD Opening Reception, two full days of pre-conference learning were open to all stakeholders, including patient advocates, administrators, clinical staff, and State Methadone Authorities (the agency at the state level responsible for overseeing the clinics in that state). For the second consecutive conference, AATOD presented a pre-conference session on "Risk Management in the OTP" (see *AT Forum* article on page 6). This session directed the attention of administrators and clinicians to areas of risk, including induction and dosing, impaired driving, and OTP liability.

During a closed pre-conference session, SAMHSA/CSAT and every State Methadone Authority arranged a meeting with federal officials from SAMSHA, CSAT, and the Drug Enforcement Administration (DEA). The purpose was to discuss government oversight issues and to hear individual state concerns. This session gave the states and the federal government a chance to learn from each other and to share innovations. At least one State Methadone Authority considered the session to be one of the highlights of the conference.

The conference plenary sessions, workshops, hot topics, exhibits, posters, and banquet were well-organized and informative, and reflected the conference theme: evidence-based treatment practices. Other topics included medication-assisted treatment in the criminal justice system, interim maintenance in the city of Baltimore, and the treatment of co-occurring disorders in OTP.

Awards Banquet

The Awards Banquet featured a presentation of the Nyswander-Dole "Marie" award *(see below)*, named after Vincent Dole, MD, and his late wife Marie Nyswander, MD, who worked together to develop methadone maintenance treatment for opioid dependence. Other honorees included Anthony Scro (Richard Lane Patient Advocacy Award) and Judge Karen Freeman-Wilson (Friend of the Field Award).

The next AATOD conference will be held in New York City, April 25 to 28, 2009. Plan to attend this important conference!

Awards

2007 Nyswander-Dole "Marie" Award Recipients

Recipients of this award were nominated and selected by their peers for extraordinary services in the opioid treatment field.

Daniel Alford, MD	*Massachusetts*
Herbert Barish, MSW	*New York*
Eric P. Ennis, LCSW	*Colorado*
Emilia Figueroa, MD	*Mexico*
Alexander Kantchelov, MD	*Bulgaria*
Marc Kleinman, PhD	*Florida*
Rebecca Lira, BA	*California*
Nora Quiason, MD	*Missouri*
Julia Shi, MD	*Connecticut*
Craig V. Showalter, MD	*Illinois*
George Stavros, MD	*Arizona*
Ellen M. Weber, JD	*Maryland*

MMT: Past, Current, Future: Part I

AT Forum recently asked Beny Primm, MD, to share his perspective on the key events that helped shape methadone maintenance treatment (MMT) over the past four decades (see MMT Timeline below). Dr. Primm, an internationally known expert on MMT and HIV/AIDS, has been a tireless advocate for comprehensive addiction treatment services, particularly in the inner city (see page 8 for a summary of highpoints in his illustrious career).

The events Dr. Primm focused on illustrate how MMT and health care workers trained in MMT have played and continue to play a key role in improving patients' lives. Health care workers in methadone treatment clinics throughout the U.S. now offer people with addiction disease the hope for a better life, free from drug cravings, and the opportunity for productive employment. Society also benefits, for MMT lowers crime associated with addiction and decreases the spread of blood-borne and related diseases, such as HIV/AIDS, hepatitis C, and tuberculosis (TB).

The 1960s: A New Hope for Addiction Treatment

Back in the 1960s, working at the Rockefeller Institute in New York City, Drs. Vincent Dole and Marie Nyswander found that methadone could effectively treat heroin addiction. They published their landmark findings in 1965 in *The Journal of the American Medical Association (JAMA).*

The team's research established that for most patients, a typical daily maintenance dose of 80 to 120 mg was sufficient to:

- Relieve narcotic craving
- Suppress the opioid abstinence syndrome for 24 to 36 hours
- Block the effects of administered heroin
- Develop tolerance to the euphoria, sedation, or other narcotic effects of methadone that would impair emotional responses, functioning, or perception
- Develop tolerance to the analgesic properties of methadone

The methadone pilot project at Rockefeller had shown its success at decreasing crime and injection-related disease. The project was transferred promptly to the Morris J. Bernstein Institute of the Beth Israel Medical Center, where it was expanded to a larger population of heroin-dependent people.

The 1970s: MMT Against a Crime Wave

Taking office in 1969, President Richard Nixon was faced with increased opioid-related drug use and a rising crime rate, including in the nation's capital. Robert DuPont, MD, a psychiatrist in Washington D.C., saw the relationship between opioid addiction and crime. The Nixon administration assisted the D.C. government to open an MMT program, patterned after one that Jerome Jaffe, MD, had established in Chicago, with Dr. DuPont as director. In 1970, the crime rate in D.C. dropped by 5.2 percent, while it rose 11 percent in the rest of the country. This, and the early evaluation of methadone treatment programs in New York City, provided real evidence that MMT lowered addiction-related crimes.

During this period, the federal government significantly increased funding directed at stemming the supply of illicit heroin entering the U.S. In addition, Nixon asked the National Institute of Mental Health (NIMH) and several other federal agencies for recommendations to counteract the alarming increase in heroin addiction. The recommendations were to step up research on drug abuse. Nixon also had a non-governmental advisory group, which proposed rapidly expanding all forms of addiction treatment, including MMT, throughout the country, rather than doing more research.

In 1971, in response to the recommendations of the non-governmental group, Nixon created a new office, SAODAP (Special Action Office for Drug Abuse Prevention). He appointed Dr. Jaffe as its first director, who reported directly to the President. As a result of this national expansion, and Dr. Jaffe's positive experience with MMT in Chicago, the number of patients receiving methadone treatment increased from 9000 in 1971 to 73,000 in 1973 (Center for Substance Abuse Treatment 2005, TIP 43 page 16).

The 1980s: MMT Helps Slow The HIV/AIDS Epidemic

By the mid-1980s, the HIV/AIDS epidemic in the drug-injecting population was affecting a significant proportion of MMT patients. By 1988, AIDS-related illnesses were the major causes of death within the MMT patient population. TB, an opportunistic disease afflicting many HIV patients taking antiviral drugs, became a major public health concern. As a result, MMT clinics became important centers for the detection and treatment of HIV/AIDS and TB.

Dr. Primm became an advocate for reducing injection-related HIV. Clearly, expanding MMT and providing oral methadone to more patients would

MMT Timeline

1963-1964
Drs. Dole/Nyswander MMT research project started at Rockefeller University

1965
Dole/Nyswander MMT research published in JAMA

1971
Nixon appointed Jerome Jaffe, MD, Director of SAODAP

1972
FDA Federal Methadone Regulations established

1974
Narcotic Addiction Treatment Act defined MMT

1981
AIDS detected in CA and NY

1984
HIV identified as cause of AIDS

Leaders in MMT at a conference in the mid-1980s. Left to right: Julio A. Martinez, then Commissioner of New York State's DSAS, now OASAS; standing is Mark Parrino, currently President of AATOD; Jim O'Hanlon, an Assistant Commissioner of DSAS/ODAS; Beny Primm, MD; Erica Spitz, Director of the Drug Abuse Project at the New York Urban Coalition (now defunct); Lazette McCants, Erica's Assistant Director; Charlie LaPorte, Deputy Commissioner for Methadone Services of DSAS/ODAS; seated are Vincent P. Dole, MD, and Marie E. Nyswander, MD.

lower the incidence of heroin injections. This, in turn, would reduce the incidence of blood-borne and related infections, such as HIV/AIDS, hepatitis C, and TB. His status and eminence in the addiction treatment community made people listen, especially in minority communities. His approach proved to be correct. MMT led to a dramatic drop in the incidence of HIV/AIDS for those in treatment, and it helped make methadone, in Dr. Primm's words, "the closest thing to an AIDS vaccine."

In 1987, President Reagan appointed Dr. Primm to The President's Commission on the HIV Epidemic. "Substance-abuse treatment is an essential part of the solution to stop the spread of HIV among the addicted population," Dr. Primm told *AT Forum*. "If you get people into treatment, you can cut down on the number of times they 'shoot up' and expose themselves to the virus through shared needles and paraphernalia. I pushed very hard when I was at OTI (Office of Treatment Improvement, later the Center for Substance Abuse Treatment) to get drug treatment programs to help prevent the spread of HIV." Dr. Primm was OTI's first director.

Dr. Primm's success is reflected in the fact that federal block grants now require monitoring HIV data, and many programs include HIV treatment. "Infected patients now account for only about 12% to 15% of patients entering drug programs in New York City—a sharp drop from what it had been, about 65%," Dr. Primm said.

The 1990s: Official Acceptance and Standardization of Programs

The 1990s brought about the official acceptance and standardization of MMT programs.

Three major reports regarding care provided by MMT programs reflected changing attitudes toward drug addiction and its treatment:

- The 1990 General Accounting Office (GAO) Report said that an artificial cap on the daily dose of methadone was often so low that patients were undertreated and continued to use intravenous heroin. The report also found that clinics did not have mechanisms in place for monitoring the results of therapy. According to Dr. Primm, "The GAO Report acted as a catalyst for changing the way MMT clinics were run."
- In 1995, the Institute of Medicine (IOM) issued a report entitled "Federal Regulation of Methadone Treatment." This report acknowledged the benefits of MMT, but indicated that federal regulations were hampering the expansion and accessibility of MMT programs. The IOM recommended that:
  - Regulations be modified to permit greater access to treatment for all opioid-addicted persons.
  - Dose levels be based on individual patient need.
- In 1997, the National Institutes of Health (NIH) issued a consensus statement on the treatment of opioid addiction. The statement:
  - Concluded that opioid addiction is a treatable medical disorder
  - Explicitly rejected notions that addiction is self-induced or a failure of willpower

The 2000s: Continuing Improvement in Treatment Programs

The key reports and new regulations of the 1990s continue to transform the MMT field. Other changes include:

- A national accreditation system implemented in 2001 is standardizing and improving opioid addiction treatment
- Buprenorphine, introduced in 2002, provides for a choice of medications for treating opioid addiction
- Continued research on opioid addiction is accelerating the incorporation of improved, evidence-based methadone treatment regimens
- Increasingly, patients' health care providers, the media, and the public accept opioid addiction as a medical disorder

Clearly, over the past four decades, MMT has made a significant impact on society—not only by directly helping individuals with addiction disorders, but by decreasing crime and the spread of needle-borne and related infections.

Dr. Primm and many other health care practitioners have worked hard to bring about these changes. *AT Forum* is grateful to Dr. Primm and others for their efforts in MMT and HIV/AIDS.

References

- Interview with Dr. Beny Primm: conducted by *AT Forum* on December 18, 2007.
- Massing M. *The Fix.* University of California Press, Berkeley. 1998. 335 pp.
- Joseph H, Stancliff S, Langrod J. Methadone maintenance treatment (MMT): a review of historical and clinical issues. *Mt Sinai J Med.* 2000 Oct-Nov;67(5-6):347-364.
- Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
- Wechsberg WM, Kasten JJ. *Methadone maintenance treatment in the U.S.* Springer Publishing Company, New York. 198 pp.

1985
AIDS-related illnesses identified as major cause of MMT patient deaths

1990
GAO report issued; HCV (hepatitis C) test was developed.

1992
Congress created CSAT within SAMHSA

1995
IOM "Federal Regulation of Methadone Treatment" report issued

1997
NIH Consensus Statement issued calling for expansion of MMT

2001
Fed Regulations revised to include accreditation process

2002
Buprenorphine approved

2005
40th anniversary of MMT

Reducing Risk In OTPs: Planning, Preparing, Preventing

This past October, Ms. Catherine H. O'Neill, Esq., Senior Vice President of the Legal Action Center in New York, presented a pre-conference session before the AATOD conference in San Diego, on risk management for Opioid Treatment Programs (OTPs). A leading expert in the field, she recently discussed OTPs' legal and liability concerns with *AT Forum*.

AT FORUM. Risk management in OTPs has certainly become a key issue. How would you describe the goal of risk management in these programs?

O'NEILL. The initial goal is to identify potential risks and problems, and to set up reasonable procedures and policies to minimize the chances they'll occur. The ultimate goal is to protect patients, staff, and the reputation of the OTP in the community.

ATF. So if it's a good program, it's a preventive program?

O'NEILL. Absolutely. It's preventive, and it's preparatory.

ATF. In your pre-conference session, did you discuss the elements of what might be considered an ideal risk-management program?

O'NEILL. Yes, we did. A good risk-management program continuously strives for quality improvement. Six areas for OTPs to focus on include:

- Patient care: clinical and procedural practices
- Competency, credentials, and training of the medical and program staff
- Program-operation issues, including discrimination, harassment, and workers' compensation
- Physical safety of staff and patients, including property-related risks
- Financial records related to the director and staff
- Regulatory requirements and compliance procedures

ATF. Are these the areas that the accreditation organizations—JCAHO and CARF—focus on?

O'NEILL. Yes. JCAHO and CARF visit clinics at least every three years, and they look for continuous quality improvement in those six clinical and administrative areas of risk management.

ATF. OTPs have been around for more than 40 years, but risk management has emerged only recently as a key issue. Why is that?

O'NEILL. Some general trends have increased awareness of risk management. In the last 10 years, the federal government has reissued certification standards and requirements for OTPs. In addition, reports of adverse events—such as methadone diversion and overdoses—have raised concerns. Adverse events have always been an issue, but increased publicity has driven OTPs to make sure that they're in compliance. And because OTPs continually seek to improve addiction treatment, they frequently reassess their programs and plan new ways of managing and preventing risks.

ATF. Litigation, too, has recently become much more common. Which legal issues in particular are OTPs concerned about?

O'NEILL. We've identified three primary types of legal issues in risk management:

- Concerns about the responsibility of the patient and the OTP, with respect to the patient's driving and the potential liability involved
- Issues related to induction into methadone treatment, and issues involving methadone overdose
- Responsibilities for preventing methadone diversion

The key questions are: What are the OTP's responsibilities? And what are the limits of these responsibilities?

ATF. Let's talk further about the first topic, driving issues and OTP risk management.

O'NEILL. Driving issues revolve around the patient's responsibility to the OTP and to the community, and the OTP's responsibility to monitor the patient's driving abilities. OTPs have been charged with negligence in a few lawsuits brought by people injured in car accidents caused by patients participating in methadone treatment. These involved patients in methadone maintenance programs who were continuing with poly drug abuse. The charge was that the OTP knew or should have known that the patient was taking methadone with other drugs, and that the OTP should have known that the interaction would impair the person's driving, and cause foreseeable injury to other people.

FAQ

Is it safe for a methadone-maintained patient to drive a vehicle?

"Research consistently shows that methadone itself is not a source of concern when it comes to driving motor vehicles. However, it should be noted that the patients tested were well-established in MMT, receiving adequate methadone doses, and not abusing illicit drugs or alcohol. Patients going through opioid withdrawal due to insufficient methadone doses, or experiencing methadone over-medication effects, such as sleepiness or fatigue, might not perform as well."

Visit www.atforum.com/SiteRoot/pages/faqs/faqs2life to read the entire FAQ.

The legal question was this: Do OTPs have a responsibility to take reasonable steps to prevent a patient from driving, if an employee thinks the patient's driving ability is impaired? And what does that responsibility mean, in terms of what OTPs must do?

ATF. That seems like an awesome responsibility. How can a provider be responsible for what a patient does an hour or more—or even many hours—after receiving a dose of methadone? How can a program be responsible for what a patient may do after their clinic visit or even know if they intend to drive or may take other drugs that impair functioning?

O'NEILL. In most states, providers of outpatient health care have not been held to have any duty to control their patients' conduct when patients are not on the premises, or to protect unknown third parties. The negligence lawsuits involving methadone patients' driving have looked at that general rule, specifically whether an exception exists when a patient takes medication and is involved in an activity that may cause harm.

Courts in a few states have found that the OTP does have the responsibility to take reasonable steps to avert foreseeable conduct of patients who are not stabilized, who are known to be driving, and whose conduct may hurt other people. If the conduct can be influenced by the program, the program should develop a plan to modify the conduct. Each program and each case requires individual analysis to determine exactly what this means. For example, does the program have a responsibility to change its level of services—or to issue a "do not drive" order—to certain patients?

ATF. What is the best way for OTPs to develop a risk-management plan?

O'NEILL. Clinics should start with the nine Federal OTP Treatment Standards of Care available online at http:dpt.SAMHSA.gov/.

The Standards list the required services. The OTP can look specifically at the risk concerns within each area, select the ones most important for their own clinic, develop strategies, and set priorities.

ATF. Let's say that a patient walks in with a three-year-old child, and the nurse who's about to give the patient his methadone dose smells alcohol on his breath. She's worried. "Will I be responsible if this patient has a car accident? Should this patient even have custody of this child?"

O'NEILL. That points out very well the concerns of front-line staff. The idea that the staff may be liable for happenings within the scope of their duties can be unsettling, unless they have a clear idea of their role.

ATF. Is there a template readers can use to manage these situations?

O'NEILL. No. Blanket policies are unsatisfactory, because they fail to monitor and respond to individual problems. Each OTP needs its own policy. Start with the Federal Standards, go over the JCAHO and CARF reviews, and come up with an individualized risk management plan. Much of risk management begins with good patient care, and then recasts good patient care in the form of a risk management program.

ATF. Let's talk about the steps in good patient care, and the staff's role related to patient interaction.

O'NEILL. First, it's important to assess each patient who comes in for treatment. Then, OTPs need to educate each patient about living, working, and functioning while on maintenance therapy. These two steps go a long way towards fulfilling risk management responsibilities.

Patient education is an absolutely critical component of risk management. Patients need to be knowledgeable not only about their medication, but also about the consequences if they fail to carry out their responsibilities. Informed patients understand their commitments. This understanding allows patients to benefit from treatment, and society to benefit from their treatment, as well.

ATF. What about educating the staff?

O'NEILL. OTPs need to educate all personnel about why risk management is essential, who is responsible for looking out for potential problems, and who will address those problems. Your story about the patient with the three-year-old child is a good example. In such situations, every staff member must have a clear idea of his or her specific role, obligations, and place in the OTP hierarchy.

Personnel need to understand that a basic requirement for OTP treatment is individualized patient care–-responses to each patient's needs as the patient moves through treatment. The staff needs to respect the rights of patients to receive good treatment, and the rights of people in the community to know that things are being run properly at the clinic. All of these concepts are important for staff members to keep in mind.

ATF. So in planning for risk management, it comes down to using the Federal Standards and the JCAHO and CARF accreditation criteria as a starting point to identify and analyze risks. Then the OTP can develop a specific risk-management program, based on the practices in its own clinic. In other words, plan to prevent problems, but also plan how to manage them if they do happen.

O'NEILL. That's exactly right.

Risk Management Checklist – Does your OTP have:

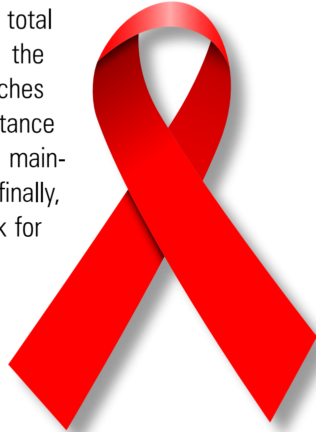
- **A defined administrative and organizational structure?**
- **Documentation for staff credentials?**
- **A clear administrative process for making staff aware of individual responsibilities?**
- **Defined patient admission criteria?**
- **Individualized induction and treatment plans?**
- **A diversion-prevention plan?**
- **A plan to keep patients from driving if they appear to be impaired?**
- **A patient-education program?**
- **A process for educating staff on emerging issues in addiction treatment?**
- **A process for creating and documenting continuous quality improvements?**

MMT Pioneer: Beny J. Primm, MD

A Champion of Comprehensive Services for Addiction Treatment

Dr. Beny J. Primm has served as the Executive Director of the Addiction Research and Treatment Corporation (ARTC) of Brooklyn, New York, since its inception in 1969. ARTC is one of the largest non-profit substance-abuse treatment programs in the country serving minority communities. ARTC provides comprehensive, multi-modality service and treatment programs for approximately 2300 men and women, primarily members of severely underserved populations.

Dr. Primm is known nationally and internationally for his total commitment to the treatment of substance abuse, and the psychological, social, and economic ills that fuel it. He teaches that all treatment modalities can be effective, that substance abuse prevention, treatment, and recovery must be mainstreamed with other human-focused disciplines, and, finally, that integration of all of these approaches is the bedrock for effective treatment.



Dr. Primm's contributions to MMT extend far beyond the medical care and social services he provides his patients. His political networks at the city, state, and federal level have drawn substantial financial aid to inner cities.

His career accomplishments include:

- Since 1983, Dr. Primm has served as President of the Urban Resource Institute, a non-profit organization providing supportive social and medical services to critical populations within New York City.
- In 1987, Dr. Primm was appointed to the President's Commission on the HIV Epidemic.
- Dr. Primm currently serves as Chairman of the Board of Directors of the National Minority AIDS Council, and is the First Vice Chairman of the National Black Leadership Commission on AIDS.
- In 1989, The Secretary of Health and Human Services appointed Dr. Primm director of the federal government's Center for Substance Abuse Treatment (CSAT), formerly known as the Office for Treatment Improvement (OTI). As director, Dr. Primm was responsible for developing programs, policies, and initiatives relating to the treatment of addictive disorders and for improving the quality and effectiveness of substance abuse treatment. During his tenure as director, Dr. Primm also oversaw the expansion of treatment capacity for the U.S. and its territories.
- In 2000, Dr. Primm was awarded the Surgeon General's Medallion for U.S. Public Health Service. The award was given in recognition of his lifetime of leadership in mental health and substance abuse treatment in the battle against the AIDS Epidemic.
- On August 6, 2003, Dr. Primm was appointed to the Presidential Advisory Council on HIV and AIDS (PACHA).

Dr. Primm earned his medical degree from the University of Geneva, Geneva, Switzerland.

A friend and associate of Dr. Primm, Mr. Ira J. Marion, told *AT Forum*, "I'm proud to say that Beny Primm has been one of my most important mentors. Since I met him in the early 1970s, I have watched as he built ARTC into a world class agency. He has traveled the world on behalf of the U.S. government and four U.S. presidents. During all, he has never wavered from his commitment to save the lives of addicted people, particularly those who are disadvantaged and those with HIV/AIDS. His work has touched hundreds of thousands of lives and he is a role model for so many working in our field. Doc is truly one of our most important leaders."

ADDICTION TREATMENT Forum
Is published quarterly
by Clinco Communications, Inc.
PO Box 685 • Mundelein, IL 60060
Phone/Fax: 847-392-3937
Publisher: Sue Emerson
Contributing Writers:
Clyde R. Goodheart, MD, MBA, MS
Barbara Goodheart, BA
Lara Pullen, PhD

© 2008 Clinco Communications, Inc.

Addiction Treatment Forum is made possible by an unrestricted educational grant from Covidien Mallinckrodt, 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.

Forum ADDICTION TREATMENT
P.O. Box 685
Mundelein, IL 60060

RETURN SERVICE REQUESTED

PRSRT STD
U.S. POSTAGE
PAID
PALATINE, IL
PERMIT # 7117