

FORUM ADDICTION TREATMENT

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PRESCRIPTION DRUG ABUSE EPIDEMIC SOARS – OTPs RESPOND

CSAT: Accessing Prescription Drug Data to Maximize OTP Patient Safety



Prescription drug monitoring programs (PDMPs), electronic databases of prescriptions submitted by dispensers (pharmacies and practitioners who dispense out of their office) and run by state agencies, are useful to help coordinate care, prevent doctor-shopping, deter prescription drug abuse, and assist law enforcement authorities in preventing diversion. As of September 2011, 36 states have operational PDMPs, and an additional 12 states and 1 territory have enacted legislation to implement a program. Most PDMPs collect data on schedules II to IV controlled substances.

This fall, a “Dear Colleague” letter from H. Westley Clark, MD, director of the Center for Substance Abuse Treatment (CSAT), encouraged opioid treatment programs (OTPs) to participate in PDMPs. The letter, released September 27, says that physicians, physician assistants, nurse practitioners, pharmacists, and other OTP staff should utilize state PDMPs “to maximize safety of patient care.” PDMPs can assist the OTP prescriber to revise their treatment plans, possibly preventing serious adverse events.

Medical Director Case Study

The letter from Dr. Clark cites a case study in which an OTP medical director found that 23 percent of patients in the OTP were prescribed significant amounts of benzodiazepines, opioids, and other controlled substances, unknown to clinic staff and revealed only by a search of the PDMP database.

The case study, a first-person account, is appended to the Dear Colleague letter and shows clearly the patient safety issues these other substances raise when OTP staff is unaware they are being prescribed. Methadone is a powerful, long-acting opioid and “can be fatal when mixed with other drugs or medications,” the OTP medical director’s account says. “Benzodiazepines, combined with methadone or other opioids, have caused many overdose deaths in our state . . . Opioids can cause overdose deaths even if not mixed with other drugs. For this reason, it’s critical to know whether or not the patient is getting another opioid in addition to the methadone we are prescribing.”

The medical director recalled that at least eight of these patients were filling prescriptions for methadone, in addition to their methadone doses prescribed by the OTP. “About half of them said they were selling or giving the methadone pills prescribed by community doctors to friends or family. The other half claimed to be taking the extra methadone themselves, with no good explanation about why they hadn’t asked for dose increases at our treatment program.”

Some patients said they had been taking prescriptions for benzodiazepines (mostly alprazolam, diazepam, or clonazepam), and “found methods to avoid detection

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In This Issue

on observed urine drug screens, some said they were giving them to friends of family members, and some admitted to selling them.” The community-based physicians prescribing these medicines didn’t know that the patients were being treated at an OTP, the medical director said. And, no one at the OTP was aware that these patients were seeing other doctors or being prescribed benzodiazepines or opioids.

The OTP medical director noted that many patients ultimately appreciated the program’s efforts to address this problem, adding that there was less drug dealing going on in the nearby parking lot. “The majority of patients were dedicated to their recovery and found the drug dealing to be a temptation and a vexation.” Also, counselors and nurses said patients who were discovered through the PDMP became compliant with treatment and indicated that the PDMP system helped with their recovery.

The case study concluded that initial and ongoing monitoring of a patient’s prescription history using PDMP data can play an important role in safe and effective addictions treatment.

OTP Patient Confidentiality Concerns

OTPs cannot provide information about their patients to PDMPs because of 42 CFR Part 2, the federal confidentiality law, and are not required to participate, the Dear Colleague letter notes. PDMPs are not bound by the confidentiality law, and could disclose identifying information about patients in OTPs, if the OTPs provided information to the PDMPs, the letter further notes. Therefore, CSAT advises OTPs not to provide information to PDMPs regarding their patients.

Chris Baumgartner, program coordinator with Alliance of States with Prescription Monitoring Programs (ASPMP), which provides technical assistance under a Bureau of Justice Assistance contract to BJA-funded PDMPs, said that if the patient got a prescription from the OTP and took it to a pharmacy, the pharmacy will input that data. But OTPs cannot participate by providing dose or dispensing information, he said.

CSAT notes OTPs should consider notifying patients about the existence of PDMPs. This also can serve to facilitate open communication with patients about their prescriptions and help coordinate care between the OTP and other medical providers.

Will Accessing PDMPs be a Barrier to Entering Medication-Assisted Treatment?

“From my perspective, I do not see a con to having programs access PDMP databases in terms of getting information,” said Mark Parrino, MPA, president of the American Association for the Treatment of Opioid Dependence (AATOD), which has been working with the ASPMP. “If there is a con, it’s basically going to be that some patients may not want to enter an OTP—word will eventually get out that programs will be accessing this data,” he said. “But frankly, I do not see this as a con.”

Mr. Baumgartner agreed that knowing that the OTP is participating in accessing information may be a barrier to treatment. “The patient may say, ‘If you’re going to monitor me, I don’t want that.’”



PDMPs are not bound by the confidentiality law, and could disclose identifying information about patients in OTPs.

For Additional Reading:

<http://atforum.com/addiction-resources/documents/dearColl-pmp2011.pdf> (Dr. Clark’s letter). Accessed November 10, 2011.

<http://www.maine.gov/dhhs/osa/data/pmp/treatment.htm> (how Maine tells OTPs to use PDMPs). Accessed November 10, 2011.

www.pmpalliance.org (Alliance of States with Prescription Monitoring Programs). Accessed November 10, 2011.

For more on the federal confidentiality regulations and OTPs, go to <http://www.atforum.com/newsletters/2010fall.php#otpconfidentiality>. Accessed November 10, 2011.

Kentucky Heads Up Interstate Prescription Drug Task Force

In the absence of a national PDMP system, people are able to cross state lines to try to get prescription drugs via doctor-shopping or visiting pill mills. That’s why

Kentucky, which has a model PDMP, is joining forces with bordering states Ohio, Tennessee, and West Virginia to create the Interstate Prescription Drug Task Force. “Our ultimate goal is for a provider to be able to go to their own state’s PDMP but to get data from other states at the same time,” said Van Ingram, executive director of the Kentucky Office of Drug Control Policy, which has the lead role over

the four-state alliance. Kentucky Gov. Steve Beshear added, “Kentucky isn’t an island. We have to attack this problem on a nationwide basis and work with other states to share information if we hope to turn around the prescription drug problem.”

All 11 opioid treatment programs (OTPs) in Kentucky use KASPER (Kentucky All Schedule Prescription Electronic Reporting) at intake, said Mr. Ingram. “If a patient is coming in to get methadone, and they are being prescribed benzodiazepines for anxiety from someplace else, this is important for the OTP to know. These are two drugs that don’t mix well.” In some cases—varying from clinic to clinic and patient to patient—the OTP may access KASPER later in treatment, as well.



U.S. Drug Strategy Focuses on Prescription Drug Abuse

The federal government has proposed a 19-percent increase in funding for domestic prevention, treatment, and enforcement dealing with the abuse of

drugs, including prescription drug misuse. The increased availability of pain medications and the misconception they are safer than illicit drugs, even if taken improperly, have led to a dramatic rise in prescription drug abuse, overdose death, and addiction across the nation.

The 2011 National Drug Control Strategy released by the Office of National Drug Control Policy (ONDCP) in July, along with the Administration's recently released plan (titled *Epidemic: Responding to America's Prescription Drug Abuse Crisis*), proposes a blueprint for reducing prescription drug abuse by 1) supporting the expansion of prescription drug monitoring programs (PDMPs) by states, 2) encouraging community prescription take-back initiatives, 3) recommending disposal methods to remove unused medications from the home, 4) supporting education for patients and health care providers, and 5) increasing enforcement to stop illegal prescribing practices and doctor-shopping.

Proposed Fiscal Year 2012 National Drug Control Budget

The President's Fiscal Year (FY) 2012 National Drug Control Budget

requests \$26.2 billion to reduce drug use and its consequences in the U.S. This represents an increase of \$322.6 million (1.2 percent) over the FY 2010 enacted level of \$25.9 billion.

National Drug Control Budget			
	FY 2012 Request (Billions)	Change from FY 2010 (Billions)	(Percent)
Prevention	\$1.7	\$0.1	7.9
Treatment	9.0	0.1	1.1
Domestic law enforcement	9.5	0.3	3.4
Interdiction	3.9	0.2	6.6
International	2.1	-0.5	-17.6
Total	\$26.2	\$0.3	1.2

Sources

For the 2011 ONDCP drug control strategy, go to <http://www.atforum.com/addiction-resources/documents/ndcs2011.pdf> Accessed November 10, 2011.

For *The Epidemic: Responding to America's Prescription Drug Abuse Crisis Plan*, go to http://www.atforum.com/addiction-resources/documents/tx_abuse_plan.pdf Accessed November 10, 2011.

For more information on the fiscal 2012 proposed budget, go to http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/fy12highlight_exec_sum.pdf Accessed November 10, 2011.

Florida Pill-Mill Crackdown Increases the Need for OTPs

The 2011 national drug strategy singled out South Florida as the epicenter of the Nation's prescription drug abuse epidemic, due to a tremendous growth in "pill mills." Between January and June of 2010, Florida practitioners purchased more than 40 million oxycodone pills, compared with only 4.5 million bought by practitioners in the rest of the country (see chart on page 4).

When federal and state law enforcement agencies began to crack down on Florida's pill-mill operations in July 2010, among the first to feel the effects were opioid treatment programs (OTPs). Need for treatment increased when pill mills were closed and the supply of prescription opioids—oxycodone among the most favored—started to dry up. The state helped by increasing the number of OTPs, adding seven new "parent" clinics and seven new satellites as of March 2011. "We knew this opioid prescription drug problem would take a while to resolve, so we needed to add OTPs," said Darran M. Duchene, state opioid treatment authority for Florida, in an interview with *AT Forum* this fall.

The new clinics were selected through a competitive bidding process to avoid having too many OTPs in one geographic area and too few in another. "We have filled all the gaps geographically," said Mr. Duchene.

Satellite Programs for Dosing and Counseling

Florida OTPs may set up satellite programs (off-site dosing stations) where they can provide methadone doses at locations other than the parent clinic, which is a way to expand capacity and make treatment more convenient for patients. "Providers can ask to set up a satellite program to reduce hardship for commuting patients," said Mr.

Duchene. The satellite program can be no more than 25 percent of the size of the parent clinic. All an OTP has to do to set up a satellite is to show that the need is there—that a critical mass of patients is traveling significant distances to get to the parent clinic. "It's open enrollment at the satellites," he said. "If the need is there, we'll approve them." Satellites are only for dosing and counseling; patients must go to the parent clinic for their initial intake evaluation, annual physicals, other medical services.

According to Mr. Duchene, the Florida system had the capacity to treat 15,000 patients before the expansion; the expansion added at least 3,000 slots.

The most prevalent problem is oxycodone, traced to both pill mills and "unscrupulous doctors," said Mr. Duchene. After the law enforcement crackdown, people who preferred oxycodone tried to find other opioid drugs. "If you shut down one avenue, drug users will turn to whatever they can get their hands on," he said.

From fiscal year 2009 through fiscal year 2010, there was a 37-percent increase in substance abuse admissions listing oxycodone as the primary drug of abuse, from 3,655 to 5,023, and an increase of



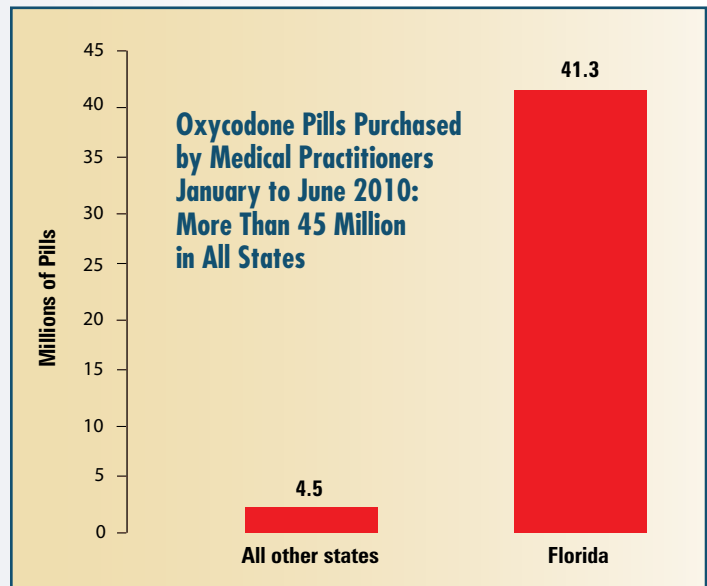
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30-percent in admissions for all non-heroin opioids, from 6,317 to 8,233. Heroin admissions declined slightly. There has been no significant change in admissions for hydrocodone, hydromorphone, or morphine sulfate as primary drugs of abuse.

Benzodiazepine Overdoses

The other big drug abuse problem in Florida is benzodiazepines, which have shown a dramatic increase in deaths due to overdose, and small increases in treatment admissions.

The benzodiazepine overdose deaths are not associated with OTPs, because every new patient admitted to an OTP is tested for these drugs. Additional testing is done depending on the phase of treatment. "The OTPs here do a much better job of testing patients than other behavioral health centers," said Mr. Duchene. Patients being treated for mental and substance use disorders in non-OTPs may be prescribed something, and then go home and take something else they have in the medicine cabinet, and not realize that the two could interact, he said.



Source: Drug Enforcement Administration, unpublished data from ARCOS (Automation of Reports and Consolidated Orders System) (February 2011).



Why Primary Care Doctors Are Walking Away From Buprenorphine

Primary care physicians in Vermont are walking away from prescribing Suboxone, saying that they are ill-equipped to treat the many problems of the opioid-addicted, the *Burlington Free Press* reported this fall. One physician, John Matthews, MD, with the Health Center in Plainfield, summed it up by saying the eight-hour course required by the federal government to be listed as a Suboxone provider is only "rudimentary" and doesn't give physicians the training needed to deal with the behavioral problems of opioid-addicted patients. "I don't want to be listed as a Suboxone provider anymore," he told the newspaper. "I'm pretty dubious about it. It's like methadone. It ought to be in the hands of an addictionologist." Contacted after the *Burlington Free Press* story was published, Dr. Matthews declined to speak with *AT Forum*.

But he and other primary care physicians have the sympathy of Peter Cohen, MD, opioid treatment authority for Maryland, where this very problem has occurred in Baltimore.

"Doctors are hesitant to start people on buprenorphine because of the implications for their practice," Dr. Cohen told *AT Forum*.

'Medication in Search of a System of Care'

"When buprenorphine first came out, I thought it was a medication in search of a system of care. The federal government said, 'We want it in doctors' offices but it's up to you to figure out how to do this,'" he told *AT Forum*. The federal government had guidelines, but it was up to states and local entities to figure out how to implement buprenorphine. In a publicly funded system, especially in an urban area like Baltimore, the solution has proved to be induction centers with intensive case management, where patients go for their first dose, and aren't referred to private physicians until they are stable and "smelling like a rose."

One big problem with buprenorphine is that the first dose can't be given unless the patient is in withdrawal. "Would a doctor who has a busy practice want someone who is going through withdrawal in their waiting room?" asked Dr. Cohen. "I'm not talking about stigma, I'm talking about logistics."

If a patient calls asking for an appointment to get buprenorphine, the physician is supposed to say to come in immediately—that day—for an appointment. That in itself is not easy for a busy physician, because the exam is time-consuming. And when the patient is scheduled for an exam, he or she is told to stop taking opioids and to come in when withdrawal symptoms begin. The entire process is cumbersome.

Induction centers are best suited to urban areas, Dr. Cohen said. "Vermont is going to be different, because it's rural." In private practice, what physicians need is a "supporting structure" if they are going to be providing buprenorphine, he pointed out. That structure is always present in OTPs. "As a physician, I know by experience that there's more to the person than the medication."

There are 325,000 to 375,000 patients taking Suboxone at any given time. About 21,500 physicians nationwide are certified to treat a maximum of 30 patients, while an additional 5,560 physicians are approved to treat a maximum of 100 patients.

For additional information:

<http://www.ncbi.nlm.nih.gov/pubmed/21664789>.

ASAM Recognizes Addiction as a Brain Disease, Supporting the Need for Medication-Assisted Treatment

On August 15 the American Society of Addiction Medicine (ASAM) published its new definition of addiction—one that contradicts some prevailing beliefs. The Society holds that addiction is not a behavioral disorder, nor is it a form of “self-medication” for easing emotional pain. Addiction is a single disease of the brain comprising a group of disorders—addiction to alcohol, opioids or other drugs, food, gambling, or sex.

A Primary, Chronic Brain Disease

The ASAM definition calls addiction “a primary, chronic disease of brain reward, motivation, memory and related circuitry.” (“Primary” means addiction is not the result of other causes, such as emotional or psychiatric problems. “Chronic” means it must be treated, managed, and monitored over a prolonged period, for some people, even a lifetime. “Circuitry” refers to nerve networks within the brain, linked with pleasurable activities and rewards—such as eating, sexual activities, and interactions with others.)

Dysfunction in the circuits leads to characteristic biological, psychological, social, and spiritual manifestations. The individual pathologically pursues rewards, or relief, or both, by substance use and other behaviors.

Addiction is characterized by craving, an inability to consistently abstain from the addictive substance or behavior, impaired behavioral control, a diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission.

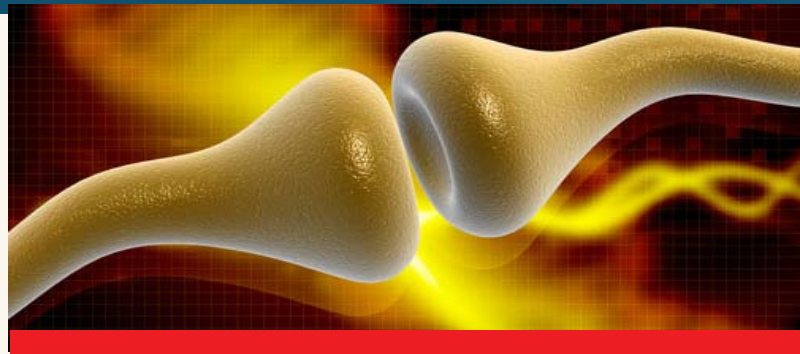
Linking addiction with brain disease did not originate with ASAM. The National Institute on Drug Abuse (NIDA) has for years reported that addiction is a “chronic, often relapsing brain disease” that over time causes brain changes that “challenge a person’s self-control and ability to resist intense impulses urging them to take drugs.” The best treatment for most patients, according to NIDA, is “combining addiction treatment medications with behavioral therapy.” Also, the National Quality Control Forum has recognized the implications of brain disease in addiction, and has recommended pharmacotherapy.

Genetic and Environmental Factors

The ASAM definition acknowledges that genetic factors “account for about half of the likelihood that an individual will develop addiction.” Genetic factors can combine with environmental factors and lead to “addiction’s characteristic bio-psycho-socio-spiritual manifestations.” More than 80 physicians specializing in addiction, neuroscience, and neurology worked together to frame the ASAM definition, which was developed over a four-year period. The definition is now out for field review and will be finalized in 2013.

Definition Supports the Need for Medication-Assisted Treatment

ASAM’s new definition of addiction explains why opioid treatment programs (OTPs) and medication-assisted treatment (MAT) help many patients with substance use disorders (SUDs)—and why some fail to benefit from treatment without medications. Methadone is effective treatment because it stabilizes brain function—a process that can take months or years—while comprehensive OTP services help patients cope with the psychosocial aspects of addiction.



Debate and Coverage

Some in the field still consider addiction to be based in behavior, not in differences within the brain. Some question whether addiction is a chronic disease. Some take issue with “spiritual factors” as contributors to addiction.

Press Comments

The following appeared in reaction to ASAM’s definition.

Hot Topics: New View of Addiction Stirs Up A Scientific Storm – The Fix ■ “A group of leading American addiction experts recently released a sweeping new definition of addiction, sending the powerful psychiatric lobby into a tail-spin.”

Time Healthland ■ Although addiction is indeed chronic in some cases, most people diagnosed with addiction or alcoholism “actually recover without treatment or participation in self-help groups.”

SARx UCLA Substance Abuse Pharmacotherapy Unit ■ “It’s hard not to ask what took them so long to come to this conclusion . . . but I guess better late than never.”

All Brain and No Soul? – The Fix ■ Social factors like unemployment, education level, traumatic life experience, and amount of social support for recovery are currently better predictors of recovery than any brain factors yet discovered.

Addiction doesn’t begin—or end—with “pleasure centers in the brain.” If we’re going to address addiction effectively, we need to recognize this reality and devote as much time and money to studying social factors as intensely as we do the brain.

Genetic factors can combine with environmental factors and lead to “addiction’s characteristic bio-psycho-socio-spiritual manifestations.”

Implications for Treatment

ASAM has cautioned that it’s “important to focus on the underlying disease process in the brain, and its biological, psychological, social, and spiritual manifestations.” It urges policy makers and funding agencies to remember that “treatment must be comprehensive, and

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to focus on all aspects of addiction and addictive behaviors, rather than substance-specific treatment.”

By defining addiction as a disease of the brain, and recommending comprehensive treatment, ASAM substantiates the key role treatment programs play in SUDs. While medication helps stabilize brain function, programs monitor regimens, maintain continuing contact, and provide services needed to help with the psychosocial aspects of addiction.

TO OUR READERS: Tell us your thoughts about the ASAM definition of addiction. Did ASAM take a bold step, or was it lagging behind the field at large? What is the role of psychosocial treatment? Tell us which services make the difference: Adequate doses of methadone? Counseling? Twelve-Step meetings?

Sources

ASAM's Definition of Addiction: *Frequently Asked Questions*. August 2011 http://www.asam.org/pdf/Advocacy/20110816_DefofAddiction-FAQs.pdf Accessed November 10, 2011.

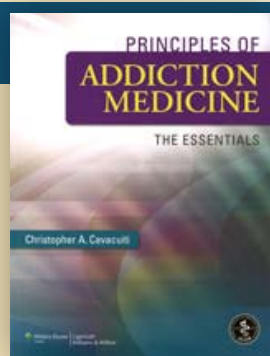
National Institute on Drug Abuse. *Principles of Drug Addiction Treatment: A Research-Based Guide*. U.S. Department of Health and Human Services, National Institutes of Health, NIH Publication No. 09-4180, Rockville, MD; 2009 <http://www.nida.nih.gov/podat/podatindex.html> Accessed November 10, 2011.

National Institute on Drug Abuse. InfoFacts: Understanding Drug Abuse and Addiction. National Institutes of Health, U.S. Department of Health and Human Services, Bethesda, MD; 2011. <http://drugabuse.gov/infofacts/understand.html> Accessed November 10, 2011.

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The Next Advancement in Counseling: The Bio-Psycho-Social Model. David M. Kaplan and Sharon L. Coogan. In *American Counseling Association: Vistas Online*. <http://www.counseling.org/Resources/Library/VISTAS/vistas05/vistas05.art03.pdf> Accessed November 10, 2011.



New Resource – Principles of Addiction Medicine: The Essentials

A new handbook from the American Society of Addiction Medicine (ASAM), *Principles of Addiction Medicine: The Essentials*, provides a quick reference on virtually all addiction medicine topics. This 600-page handbook extracts and summarizes key clinical points from each chapter of *Principles of Addiction Medicine, 4th Edition*, and presents them in an easily readable manner. The book is an excellent reference for a wide variety of practitioners, among them psychiatrists, psychologists, nurses, social workers, internal medicine and primary care physicians, and substance abuse counselors. Further information including the table of contents and ordering information is available at: <http://www.asam.org/PrinciplesEssentials.html#TOC> (Publication date May 2011; paperbound edition \$67.95 plus shipping and taxes; Kindle price \$51.29.)



Methadone Treatment Expansion in Baltimore Reduces Waiting Lists

Baltimore, once called by the Drug Enforcement Administration the “heroin capital of the U.S.,” no longer deserves that epithet, says Yngvild Olsen, MD, MPH, medical director and vice president of clinical affairs at Baltimore Substance Abuse Systems, Inc. (BSAS). More

heroin users are getting into treatment, including methadone maintenance, thanks to Maryland’s newly expanded Primary Adult Care (PAC) health coverage program. Maryland Medicaid is now paying, for the first time, for comprehensive medication-assisted treatment (MAT) for everyone who qualifies financially, opening up publicly funded methadone treatment to single men without dependent children.

The revised PAC program took effect in January 2010. It was an expansion of the original PAC program, which allowed uninsured people not eligible for traditional Medicaid—mostly childless low-income men—access to outpatient mental health services, prescriptions, and primary care. The one thing the program did not cover was addiction treatment.

Increased Medicaid Reimbursement Rate for Methadone Treatment

In 2009, the Maryland state legislature voted to take \$6.7 million

from state substance abuse treatment funds and moved it to Medicaid. In return, Medicaid increased the reimbursement rates for methadone maintenance (MM) treatment, as well as for intensive outpatient and outpatient addiction treatment. Medicaid also made these services part of the PAC benefit package.

“They got rid of the preauthorizations and a lot of other things managed care organizations put up to limit access,” says Dr. Olsen. “Methadone programs now just have to submit notifications of treatment with a clear clinical rationale for why a patient needs this treatment. Every 26 weeks, the program then repeats the process for that patient.”

Some programs expanded their actual physical space, while others maximized patient capacity within their current space.

As a result of these changes to the PAC program, opioid treatment programs (OTPs) have been able to admit new patients and access the higher rates. Some programs expanded their actual physical space, while others maximized patient capacity within their current space. They hired more counselors and expanded their hours. In addition, new private programs opened in Baltimore, or added new sites.

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Waiting Lists

The expansion has virtually eliminated waiting lists in the programs that are reimbursed by the higher Medicaid rates under PAC, says Dr. Olsen. There are 12 OTPs in Baltimore that currently receive grant funds in addition to PAC reimbursement. As of October 3, 11 responded to a BSAS query about OTP waiting lists.

Of the 11 programs that responded, three hospital-based programs still have waiting lists as they cannot access the rate structure of the PAC program and are primarily dependent on grant funds. Because of this, these three programs with waiting lists are representative of how the entire OTP system looked prior to PAC, says Dr. Olsen.

Of the remaining eight community-based programs, three have waiting lists of one to four weeks for uninsured individuals, but no waiting list for those with PAC or another form of insurance.

The other five programs have no waiting lists either for uninsured or insured patients, and are continuing to increase their capacity,

by expanding the location and by extending service hours, she says. "These programs also told us that they can expand because uninsured patients often get PAC within 60 days of treatment admission."

The survey does not include the private programs in Baltimore that do not receive grant funds but do accept PAC, but Dr. Olsen says she doesn't think there is a waiting list at these clinics for insured patients based on information circulating in the community.

Peter M. Cohen, state opioid treatment authority for Maryland, confirmed that there are no long waiting lists for methadone in Baltimore. And here's the proof. Baltimore had four interim methadone maintenance programs designed to get people in MM treatment right away. As of July 1, "we determined the need isn't there for those interim programs."

There are currently 2,231 methadone slots for the uninsured in Baltimore, and about 500 to 600 patients are maintained on buprenorphine.

Methadone Clinic Wins NIMBY Battle in Warren, Maine

A victory in Warren, Maine for CRC Health Group is a victory for methadone clinics seeking sites across the country. It also means that a community that was staunchly opposed to a methadone clinic will have the chance to see how an opioid treatment program (OTP) can operate as a good neighbor. After a yearlong battle, the town voted to settle a lawsuit filed by the Cupertino, California-based treatment program—and to grant permits and approvals for an OTP there.

The lawsuit also asked the town for \$320,000. In September, the town voted to settle the lawsuit for what ended up being only \$1—and for the right to operate a methadone clinic. The town's insurer paid the remainder of the \$320,000 to CRC.

Background

Ever since Turning Tide, a methadone clinic in nearby Rockland, was shut down by the Drug Enforcement Administration during the summer of 2010, that area of Maine has been without needed help for people with active addiction to opioids, now a serious epidemic in the state. CRC Health Group tried to open a program in Warren, which is near Rockland, but the town of Warren issued a moratorium on methadone clinics, to block CRC and any others from opening an OTP there.

This was a classic NIMBY (not in my backyard) response, one based on "emotions," explained Jerry Rhodes, Chief Operating Officer of CRC and past president of its recovery division, speaking to *AT Forum* in October. But CRC filed suit and won. The company sued based on the Americans with Disabilities Act, which bans discrimination based on disabilities; addiction is a disability.

Over the course of the past year, CRC officials explained to the town that most of the patients in the OTP would be addicted to prescription drugs and not using needles, and gave scientific presentations on how effective methadone is. The town dug in its heels all through late last year and early this year. CRC's lawyer wrote a letter to the town last winter warning that if the town did not reinstate the building permit



previously given to its methadone program there, and repeal the moratorium, there would be "immense liability" to the town.

One Day of Mediation

"We had to file suit against the city, unfortunately," Mr. Rhodes said. The resolution came about through mediation. "They came to realize that we were right." The mediation process did not take a long time, but it was "fairly intense."

At the August 31 mediation, the town learned that it could be facing two years of costly time in court, and that it would probably lose its case.

In the case of Warren in particular, "it didn't seem as if they were well-advised, or had thought this out," Mr. Rhodes commented.

Emotions

The field needs to work harder to educate people about medication-assisted treatment, Mr. Rhodes said. "I've done this for a long time, and many people have an emotional, almost visceral, reaction. They don't have a good understanding of the basis of addiction. People clearly aren't aware of the gravity of the problems in their own community."

When people in Maine read the many news stories about the epidemic of prescription opioid abuse in the state, they are somehow not connecting this to the communities they live in. People also need to realize that installing a clinic that provides services for opioid abusers

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MORE NIMBY NEWS

Meanwhile, in Berwyn, Illinois, the Buonauro Clinic is seeking to open a new facility (one already exists in Evanston). Just as in Warren, Maine, the permit was initially granted, and then rescinded after community protests; voters then voted to ban methadone clinics in certain areas. The owners sued the city, claiming it violated the ADA. The lawsuit is seeking \$1 million in damages and issuance of a business license.

The suit was filed in U.S. District Court in Chicago by clinic owners Elizabeth Buonauro and Sal R. Sotille.

Evidence was presented at trial in October, with more information to go to the judge over the course of the next couple of months, and a ruling is expected in January.

"can be a positive thing for the area," Mr. Rhodes explained. "Treatment programs reduce crime and help people improve their lives."

The coming days and weeks will be spent on integrating the clinic into the community, in preparation for the actual opening, said Mr. Rhodes. "I'm not expecting we'll see any overt negative reaction. Things tend to settle down, and they will realize we're not the problem they anticipated."

EEOC Sues Employer for Discriminating Against Methadone Patient



The federal agency charged with keeping discrimination out of the workplace has good news for methadone patients in medication-assisted treatment. In a lawsuit filed last summer by the U.S. Equal Employment Opportunity Commission (EEOC) against United Insurance, a Chicago-based company, the federal government is fighting for the rights of people in methadone treatment for opioid dependence. According to the complaint, United Insurance offered a position as an agent to Craig Burns, who has

been in methadone treatment since 2004. The job offer was contingent upon his passing a drug test; Mr. Burns' test indicated that he had methadone in his system.

Mr. Burns' treatment provider gave him a letter for the company saying that he was in treatment and taking a legally prescribed medication. When the company got that information, it withdrew the job offer, according to the EEOC, which charges that United Insurance violated the Americans with Disabilities Act (ADA).

Past Drug Addiction is a Protected Disability Under the ADA

The EEOC sued United Insurance in the U.S. District Court for the Eastern District of North Carolina. "It is unfortunate that many employers still deny the opportunity for work to people who are ready and able simply because of inaccurate perceptions of disabilities," said Lynette A. Barnes, regional attorney for the EEOC's Charlotte District, in a press statement in August. "Employers' decisions are often based on irrational fears or stereotypes about individuals with a record of past substance abuse. The EEOC will continue to fight for the rights of people victimized by such prejudices."



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Contact: [www.asam.org/
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Events to Note