Narcotic Replacement Therapy Policy

San Mateo County

Alcohol and Other Drug Services

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The Narcotic Replacement Therapy (NRT) Policy

- "Narcotic replacement programs (formerly known as methadone programs) are the preferred treatment for opiate dependence".
- "It is the policy…that services to qualified consumers not be delayed/withheld due to the consumer's medical status as it relates to narcotic replacement drugs (methadone or buprenorphine)"

NRT Policy (continued)

- “A consumer…seeking non-residential or residential treatment can have concurrent NRT detox or maintenance under certain conditions and on a case by case basis”.
- Consumers must comply with all laws and established guidelines (Title 9 Narcotic Treatment Programs).

NRT Policy (continued)

- “All consumers with an identified Primary Opiate Dependence shall be notified of the following:
  - NRT is the most widely known and well-researched treatment for opiate dependency;
  - A referral to the methadone clinic or appropriate medical practitioner will be made upon the consumers request and by the current provider”

NRT Policy (continued)

- “Treatment providers shall also develop guidelines and procedures consistent with County Policy”
- “Any consumer who feels that they have been denied services in any other modalities of treatment services (outpatient, residential, day treatment, etc.) due to their participation in a narcotic treatment program may contact the Alcohol and Drug Administrator at 650-802-6400 to file a complaint. Narcotic Treatment Providers are also encouraged to report any perceived violation of this policy”.

Acronyms

- MMT---Methadone Maintenance Therapy
- OBOT---Office Based Opioid Treatment
- ORT---Opioid Replacement Therapy
- Taper = Detoxification

A brief history of opiate addiction

- Civil War: Widespread opiate addiction
- 1874: Heroin synthesized
- Early 1900's salesmen, pharmacists, doctors freely sell/distribute all forms of opiates and create 300,000 addicts—largely an iatrogenic illness.

- 1950's – Present: Heroin use intensifies after WWII, and escalates in 1960's.
- Nixon Administration—After a much publicized "war on drugs", greatly increased methadone funding.

Methadone. In brief……

- Methadone is widely utilized throughout the world;
- Methadone is the most widely researched treatment services intervention
- Methadone is the most effective known treatment for heroin addiction

Institute of Medicine. *Treating Drug Problems, vol. 1: A Study of the Evolution,Effectiveness, and Financing of Public and Private DrugTreatment Systems*. Washington, DC: National Academy Press; 1990:187.

Buprenorphine (Subutex)

- Approved in 2002 to treat opiate addiction
- Intended to be taken sublingually
- Difficult to get euphoric response or to overdose (when taken alone)
- Partially blocks the effects of other opiates (so difficult to get high)
- Can stay in system up to three days
- *Compliance/Adherence can be a challenge

*Buprenorphine for the treatment of opioid dependence. Lisa A. Boothby and Paul L. Doering American Journal of Health-System Pharmacy, Vol. 64, Issue 3, 266-272

Methadone

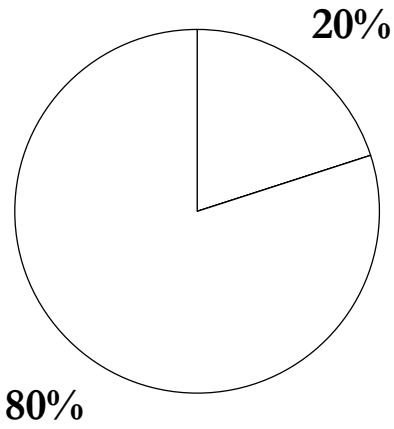
- Used as an agonist (to replace other opiates) in treatment for over 30 years
- *Office of National Drug Control Policy: “Heroin releases an excess of dopamine in the body and causes users to need an opiate continuously occupying the opioid receptor in the brain. Methadone occupies this receptor and is the stabilizing factor that permits addicts on methadone to change their behavior and to discontinue heroin use”.

*****ONDCP Fact Sheet, 2008

Methadone and Heroin: In Review

	Heroin	Methadone
Route of Administration	Intravenous	Oral
Onset of Action	Immediate	30 Minutes
Duration of Action	3-6 hrs.	24-36 hrs.
Euphoria	First 1-2 hrs.	None
Withdrawal Symptoms	After 3-4 hrs.	After 24 hrs.

Background



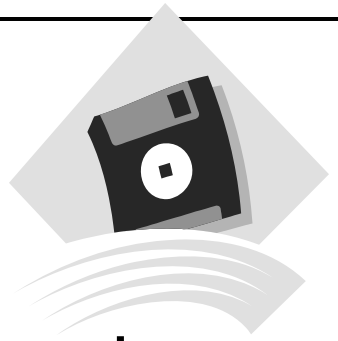
- *About 20% of approximately 810,000 heroin addicts in the U.S. receive methadone maintenance therapy (MMT)
- Methadone costs about $13/day
- **Cost benefit ratio of about 1:4 (for every $1 spent, $4 saved)

*American Methadone Treatment Association, 2004 **COMPA, *Regarding Methadone Treatment: A Review,* New York, NY, pp. 6, 9, and 10, 1997

What does methadone do?

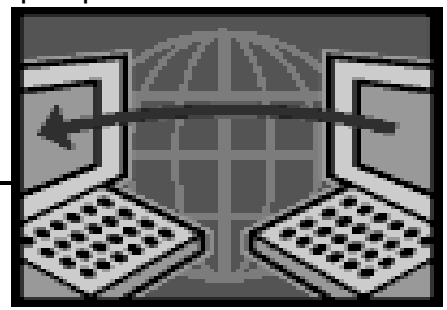
- Blocks the craving for opioids (major factor in relapse) by occupying receptor sites
- Suppresses symptoms of opioid withdrawal for 24-36 hours
- Diminishes effects of administered heroin
- Does not cause (or significantly reduces) euphoria, intoxication, or sedation

The Data is In



- Methadone's best (and sometimes only) friend is research: most evaluated of all treatment interventions
- *4 out of 5 persons who taper relapse back to intravenous drug use
- Difficult to identify who can be maintained without methadone

*Dole, V.P., and Nyswander, M.E. Methadone maintenance treatment: A ten-year perspective. *JAMA* 235:2117-2119, 1976.



Effectiveness of MMT

- Reduction in illicit drug use
- Reduction in criminal activity
- Reduction in needle sharing and HIV infection
- Reduction in commercial sex work
- Improvement in social health
- Improvement in health
- Retention in drug treatment
- Reduction in suicide
- Reduction in lethal overdose

Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence.

Amato L, Davoli M, Perucci C, Ferri M, Faggiano F, Mattick RP. An overview of systematic reviews of the effectiveness of opiate maintenance therapies: available evidence to inform clinical practice and research. *Journal of Substance Abuse Treatment* 2005;28(4):321-29.

Methadone and Health……

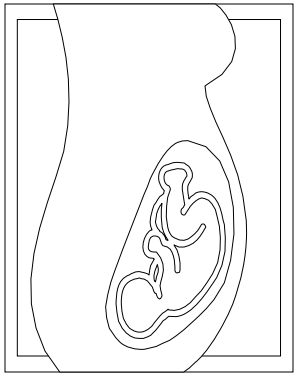
- The most significant health consequence of long-term methadone treatment is a marked improvement in general health*
- Concerns about methadone's effects on the immune system have not been borne out in studies**
- Concerns about methadone's effects on the kidneys, liver, and heart have also not been borne out in studies***

*NIDA Treatment Research Monograph Series. DHHS Pub. No. (ADM) 83-1281. Rockville, MD: U.S. Department of Health and Human Services; 1983.

**Center for Substance Abuse Treatment. *State Methadone Treatment Guidelines*. DHHS Publication No. (SMA) 93-1991. Rockville, MD: U.S. Department of Health and Human Services; 1993:138.

***National Institute on Drug Abuse. *Medical Evaluation of Long-Term Methadone-Maintained Clients*. NIDA Services Research Monograph Series. DHHS Publication No. (ADM) 81-1029. Rockville, MD: U.S. Department of Health and Human Services; 1990.

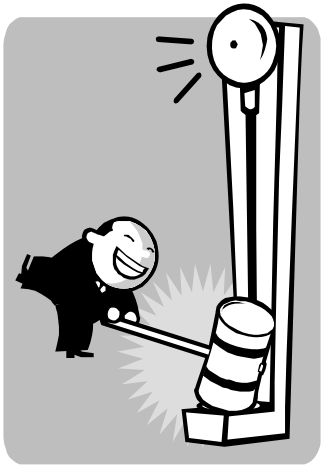
MMT and Pregnancy



- Since 1970, MMT has been used successfully/approved for use with pregnant women
- The consensus is that methadone can be used safely during pregnancy with little risk to mother and infant

Kaltenbach K, Silverman N, Wapner R. Methadone maintenance during pregnancy. In: Center for Substance Abuse Treatment. *State Methadone Treatment Guidelines*. DHHS Publication No. (SMA) 93-1991. Rockville, MD: U.S. Department of Health and Human Services; 1993:85-93;

Who benefits most from MMT



- *Older
- *Married
- **More social support
- **Less severe psychiatric disorders
- ***Sustained benefit even with minimal or no counseling - has been shown in five randomized trials to be much more effective than no treatment

*McLellan and Farley et al., as cited in Strain, 1999b, 76

**Darke, S. (1998b). The effectiveness of methadone maintenance treatment 3: Moderators of treatment outcome. In J. Ward, R. P. Mattick, and W. Hall (Eds.), *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*

***Gunne & Grönbladh; Yancovitz et al.; Dole et al.; Vanichseni et al.; Newman & Whitehill, 1998

Persons on NRT and Recovery Treatment Services: Rationale

- Individuals may be using and be addicted to multiple illicit and/or prescription drugs and/or alcohol—and out of control
- Addiction may be persistent and require medication to improve behavior/functioning
- Persons may benefit from the stabilizing effect of recovery services
- Retention in treatment is critical for success
- Tapering increases risk of relapse

Retaining People in Treatment

- Methadone clients have high retention rates. Persons on MMT have substantially higher rates compared to outpatient counseling without methadone or residential programs without methadone.
- Although achieving a sustained drug-free state is an "optimal treatment goal," the evidence indicates that this goal cannot be achieved by most individuals who are dependent on opioids

National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction (1998). Effective medical treatment of opiate addiction. *JAMA, 280*(22), 1936-1943.

Maintenance May be Optimal Disposition

- The majority of clients/patients will resume heroin use if they stop taking methadone (Ward, Mattick & Hall, as cited in Ward, Mattick and Hall, 1998c, 337)

- 82% of the patients relapsed to intravenous drug use after having been out of methadone treatment for 10 months (Lowinson et al.,1997, 412)

- Ward et al. (1998b, 329) conclude that the goal of treatment for most people who are opioid dependent should be *maintenance* on methadone. This is because a maintenance orientation increases the likelihood that people will remain in treatment - and will thereby achieve the individual (and societal) benefits of treatment. Length of time in treatment was the "major factor in outcome."

Dose is Critical

- Review of the results of 11 randomized controlled trials and several observational studies: There is a clear dose-response relationship between methadone dose and heroin use. The likelihood that clients will use heroin decreases as the methadone dose increases
- Dose is not a reward or punishment
- Metabolism and body size/weight not perfectly correlated

Ward, Mattick and Hall. (1998h, 217-222)

Not a Cure-All

- Although methadone maintenance treatment is effective, it is not a "cure" for opioid dependence.
- Many people who receive treatment actually continue to use illicit or unauthorized Rx drugs, although at a reduced rate (Hall et al., 1998b,).

Drug Screening for Persons on Methadone

- Persons in treatment may be drug tested with same policy/procedure utilized for all clients
- Testing procedures for persons on other psychotropic medications and methadone may be identical (i.e., notification to testing service of rx'd medication)
- All negative (clean) screenings may be positively rewarded (contingency management)

When to Taper

- Never (difficult to predict who will relapse)
- When client requests the taper (client desire)
- *When client shows strong signs of rehabilitation (employed or student, housed, no illicit drug use, good social network)
- Always in conjunction with *medical* advice

***Ward, J., Mattick, R.P., and Hall, W. Methadone Maintenance Treatment and Other Opioid Replacement Therapies, 1998.**

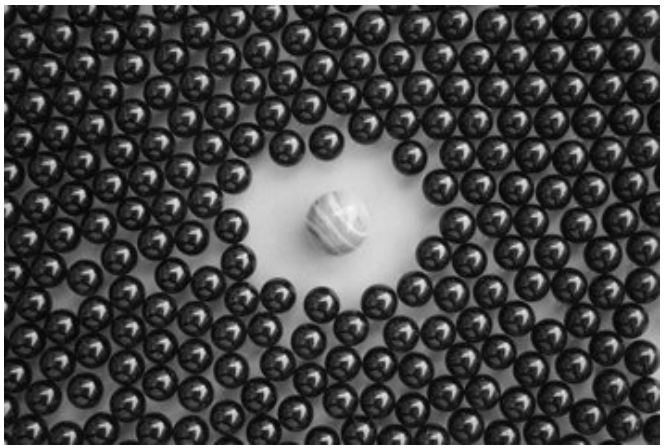
Program Vs. Individual Factors

- More program factors, rather than individual factors are associated with positive outcomes for MMT

  - Sufficient dose
  - Retention in program
  - Available ancillary and counseling services
  - Flexible abstinence policy (to allow for MMT to be maintained) or chance of successful outcome is small

Methadone in the Treatment Milieu

- Stigma concerning methadone must be actively and repeatedly confronted;

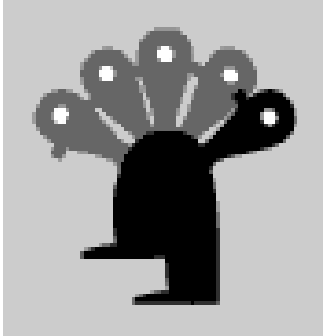


- Staff must role model open, tolerant, informed positions;
- Policy: Methadone is a psychotropic medication, a clinical tool, and person on MMT is fully accepted by peers and staff.

Community Relationships

- Addicted persons not on methadone may be jealous (and even bitter) toward people on methadone
- The reverse is also true…persons on methadone become jealous of persons going through treatment “drug free”
  - Persons in treatment need consistent opportunities to discuss and process these issues
- Methadone Groups within the treatment program can help work through these issues

Nodding: Aroused Sleepiness



- Not acceptable
- Clients need to take responsibility
  - w/ staff support
- Split dose (twice daily)
- Behavioral Interventions (standing during group, cold water)
- Doses cause different reactions among and between individuals

Programming considerations

- Written policies
- Methadone Counselor
- Methadone training considerations
  - Education (the data)
  - Sensitivity/stigma control
  - Venue for staff concerns/fears
  - Strategy for patient education
  - Strategies for patient interaction

Logistics: Two Treatment Programs

- MMT often requires daily visits to methadone program for most persons
- Transportation and scheduling
- Coordination of support services with NRT staff
- Ability to pay
- Develop working collaborative relationship with methadone program staff

Logistics: Methadone Clinic and Recovery Programming

- Release of information
- Client understanding that programs will work together
- Separate $ relationships
- Coordination of care….
  - Dosing times/schedules
  - Counseling roles
  - Drug testing

Office Based Opioid Treatment

- 1999 federal regulations extend the treatment options of methadone-maintained opioid-dependent patients from specialized clinics to office-based opioid therapy (OBOT).
- OBOT is the treatment of opiate addiction with methadone or buprenorphine in a physicians' office and outside of the clinic system. Each medication has specific requirements and regulations before it can be dispensed from a physicians office.
- Physician must request exemption to be eligible

Complementary Programming

- 12 Step Methadone
- Methadone Support Groups within the treatment program for persons on methadone
- Educational seminars for everyone in the program, regardless of pharmacotherapy routines/regimens
- Methadone support person within the treatment community
- Role Modeling (staff on methadone)

In summary, methadone is not without controversy……

- Responsibility to serve all clients regardless of our biases
- Responsibility to provide best tools available that clients are able to utilize and benefit from
- Individualized care requires matching interventions to best meet the needs of clients
- Bias and stigma are barriers to effective care

The End……..

Questions