Journal of Substance Abuse Treatment 37 (2009) 362–367

Journal of Substance Abuse Treatment

Regular article

Scaling-up interim methadone maintenance: Treatment for 1,000 heroin-addicted individuals

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Received 6 February 2009; received in revised form 1 April 2009; accepted 3 April 2009

Abstract

The objectives of this study were to determine the following: (a) the feasibility of expanding interim methadone treatment (IM), (b) the impact of IM on heroin and cocaine use, and (c) the effect of charging a modest fee for IM. Six clinics provided daily methadone plus emergency counseling only (IM) to heroin-addicted individuals on a waiting list for treatment. IM was provided for up to 120 days before transfer to regular methadone treatment. Drug testing was conducted at admission to IM and at transfer to methadone treatment program (MTP). Half the patients were charged $10/week for IM. Logistic regression analysis was used to determine the effect of fee status and other variables on transfer. Of 1,000 patients enrolled in IM, 762 patients (76.2%) were admitted to a regular MTP. For those who transferred (n = 762), opioid-positive tests decreased from 89.6% to 38.4%; cocaine, from 49.9% to 44.9% from admission to transfer. Logistic regression analysis indicated that fee status at baseline was not significantly associated with transfer. When limited public resources create waiting lists, IM can allow additional patients to sharply reduce heroin use while waiting for admission to MTP. © 2009 Elsevier Inc. All rights reserved.

Keywords: Heroin addiction; Methadone treatment; Interim methadone

1. Introduction

In the United States, where oral methadone has been used to treat addiction since 1965, federal and state regulations instituted in 1972 mandate the provision of various rehabilitative services along with medication. This requirement, originally based on the belief that methadone alone was not likely to have much impact on changing the behavior of heroin-addicted individuals, continues to be in effect under current program accreditation systems and substantially raises the cost of providing oral methadone to those heroin-addicted individuals who might benefit from methadone alone. Over the past 30 years, the public's willingness to support rehabilitative services has waned, and in many parts of the United States, methadone maintenance treatment is now available only to those who can pay for it or whose private insurance will cover it. At present, more than one third of methadone treatment programs (MTPs) are private, for-profit operations (Northrop Grumman Information Technology Health Solutions, 2006). The net effect of declining public support and the shift to for-profit programs is that many heroin users seeking entry to an MTP are placed on waiting lists until limited publicly subsidized openings become available (Des Jarlais, Paone, Friedman, Peyser, & Newman, 1995; Lewis, 1999; Peterson et al., 2008).

Waiting lists for methadone treatment in the United States have existed for the past four decades (Friedmann et al., 2003; Patch et al., 1973; Wenger & Rosenbaum, 1994). The lack of access to methadone treatment is an international

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0740-5472/09/$ – see front matter © 2009 Elsevier Inc. All rights reserved.
doi:10.1016/j.jsat.2009.04.002

problem as well, and waiting lists have been described in Europe, New Zealand, and elsewhere (Adamson & Sellman, 1998; Fountain et al., 2000). In Baltimore at the time of this study, individuals remained on waiting list prior to entering methadone treatment for approximately 3 months (Schwartz et al., 2006). In the 1980s, when data indicated that MTP patients had a reduced likelihood of becoming infected with HIV, efforts were undertaken to reduce waiting lists or at least to provide oral methadone for those awaiting admission to MTPs. Dr. Vincent Dole and Dr. Donald des Jarlais obtained an Investigatory New Drug (IND) Application from the Food and Drug Administration that would allow the provision of methadone to heroin-addicted individuals who otherwise would have remained on waiting lists. A study conducted under this IND, which randomly assigned heroin-addicted individuals on an MTP waiting list to remain on the list for 30 days or to receive methadone without counseling (which these authors termed *Interim Maintenance*), found that individuals on interim methadone treatment (IM) had lower rates of heroin use at 30 days postenrollment and were more likely to be enrolled in MTP at 16-month follow-up (Yancovitz et al., 1991). In an editorial, Dole (1991) noted that although the Yancovitz study was a successful preliminary test of minimal service methadone, programs striving for a public health impact must be brought to scale to treat a significant proportion of the addicted population.

Calsyn et al. (1994), in a 3 × 2 factorial design, randomly assigned new MTP admissions to one of three counseling conditions (methadone only, methadone with standard counseling, and methadone with enhanced counseling) and one of two contingency contracting conditions (yes vs. no). There was no effect of the level of counseling on 12-month treatment retention rates and no main effect of counseling level on the mean number of opiate or cocaine-positive urine tests. Subsequently, new federal regulations permitted IM treatment (Federal Register, 1993) but were rarely implemented. A study in Baltimore demonstrated that individuals randomly assigned to IM as compared to remaining on a waiting list were significantly more likely to enter MTP, as well as reduce heroin use and self-reported criminal behavior (Schwartz et al., 2006, 2007). The present project was conducted following the trial in Baltimore to determine the feasibility of scaling up IM treatment in six different MTPs to treat more than 1,000 patients and to determine the impact of charging a modest copayment on treatment outcomes.

2. Methods

2.1. Participants

In Baltimore in 2005, heroin-addicted individuals seeking methadone treatment typically waited many weeks or months because of a relative shortage of publicly subsidized openings in existing programs (Schwartz et al., 2006). From January 2005 to June 2006, six Baltimore area MTPs admitted heroin-dependent patients to IM from their individual waiting lists. For admission to IM, applicants had to meet criteria for entry into a MTP (Federal Register, 1993).

2.2. Exclusion

Pregnant women, and in some MTPs individuals with positive urine tests for benzodiazepines, were excluded from participation in IM; the former were admitted to the comprehensive MTP and referred for obstetrical care, whereas the latter were referred to detoxification from benzodiazepines if required or asked to return for an additional screening with a negative urine test for benzodiazepines.

2.3. IM procedures and additional assessments

All those individuals admitted to IM received the same medical, laboratory, and baseline psychosocial assessments as those admitted to regular MTPs. IM treatment consisted of providing directly observed methadone administration and only emergency counseling. Methadone doses were provided following the same induction schedule used in the clinics for patients in their comprehensive methadone programs and generally began with 20 mg and increased roughly by 5 mg every day (or every other day) to a target of approximately 80 mg. Doses were then adjusted at the request of the patient through discussion with the medicating nurse and approval of any dose changes by physician order. Consistent with the federal regulations (Federal Register, 2001), there were no take-home doses, and all clinics remained open Sundays and all holidays. Patients consented to methadone treatment and were provided an information sheet about the evaluation that was approved by the Friends Research Institute's (FRI) Institutional Review Board. Each program agreed to accept a certain number of IM patients over a period of 18 months. Three of the six MTPs charged a modest copayment of $10/week for the first half of their patients, and the other three MTPs provided free treatment. After approximately half of their patients were admitted, each clinic changed its fee policy for new admissions with those clinics who had been charging $10/week for providing IM switching to no charge and vice versa.

Patients were permitted to remain on IM for up to 120 days, after which time they were to be transferred to usual methadone treatment at their respective clinic and to participate in counseling on a regular (usually weekly) basis; they also were offered services that varied with the clinic and more frequent drug testing. However, clinics were permitted to admit patients to regular treatment as a treatment slot became available and program capacity allowed (see below). Patients were not permitted to refuse a treatment slot, although they were permitted to a dose taper to discontinue program participation.

At each clinic, patients were assessed at baseline by the MTP staff using the Center for Substance Abuse Treatment Government Program Results Act (GPRA) Client Outcome Measure for Discretionary Programs, as required by the

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