DRUG ADDICTION SERVICES OF HAWAI'I

Hui Ho'omaika'i Ika Poe O Hawai'i

JANUARY 2007 NEWSLETTER

Web Site: www.dashhawaii.org

Vol. 5, No. 9

The concept that methadone is just "liquid heroin" is a myth which abstinence-based proponents have tried to use in an argument against the concept of medication-assisted recovery. Statistics have consistently shown that methadone treatment is the standard for successful opiate addiction recovery. In terms of financial benefit, for every dollar spent on methadone treatment, $38 is saved in social and health costs. In terms of methadone's benefit to addicts, 77% stop using opiates while on methadone treatment and 63% stop using all illicit substances, even though methadone is designed to only prevent recurring relapse to opiates. These are statistics that cannot be ignored, as they show the benefit methadone has on the opiate addicted population; a population that has grown exponentially over the last decade. The question remains, however, of why certain people harass and/or 'look down on' a patient taking methadone, when the medication is doing its designed function – keeping the patient from relapse to opiates? Would the same be said to patients who are taking medications for asthma or diabetes? If the medication is doing its designed function and keeping the patient from having an asthma attack, or the patient's blood/sugar levels are normal, should s (he) discontinue the medication? The absurdity of this notion is profound. But because methadone is designed to prevent relapse to opiate addiction and is in itself a medication which causes dependence, people automatically assume that it is just "trading one form of addiction for another." Nothing could be further from the truth. ***"Knowledge is Power!"*** **"HAPPY NEW YEAR TO ALL!"** **Newsletter Editor: Cricket**

Practice Pointers: Dealing with "Situational Abstinence Syndrome"

Unexpectedly, a patient long stabilized on methadone maintenance treatment (MMT) for months or even years complains of insomnia, unusual sweating, joint aches and pains, or constant sniffing. The patient requests a methadone dose increase. What's happening here?

Common Occurrence

This is a common occurrence, according to Edwin Salsitz, MD, Director of Methadone Medical Maintenance at Beth Israel Medical Center, New York. Unfortunately, asking for a dose increase is often viewed as a sign of instability in the person's recovery.

A first question asked of the patient by clinic staff might be, "What did you take last night to bring this on?" But that would be a wrong reaction, Salsitz believes. There could be a number of reasons behind this, once a bout of flu or other disorder is ruled out.

Salsitz notes that these surprising withdrawal symptoms represent what might be called "Situational Abstinence Syndrome." It is similar to "breakthrough" pain in someone on a previously adequate regimen of analgesics, or unexplained blood pressure elevation in a patient stable on antihypertensive medicine.

Problematic Stress

A major culprit behind situational abstinence syndrome is stress. In this regard, it is absolutely critical that the symptoms are considered in the total context of the patient's life.

Traumatic events, such as the tragedies of last September, death of a loved one, divorce, loss of a job, and many others can create added stress.

(Continue – inside)

Patient Safety & Comfort Are Essential When Stopping Opioids

According to Lee A. Kral, PharmD, BCPS – author of "Opioid Tapering: Safety Discontinuing Opioid Analgesics" – guidance for starting medications is readily obtained from product package inserts and reference sources; however, it is more difficult to find information about switching or stopping opioid medications. Kral is a Faculty Member at The Center for Pain Medicine and Regional Anesthesia at The University of Iowa Hospitals and Clinics in Iowa City, IA.

Currently there is no standard protocol for tapering opioids; however, there are some suggested guidelines. Regardless of the reason for tapering opioids, the plan must be individualized to each patient's needs, and close follow-up and psychosocial support are essential. The most important factor to consider is how acutely the taper or conversion is needed.

Tapering Reasons, Settings, Duration

There are many reasons for considering opioid tapering, both from healthcare provider and from patient perspectives. Patients may decide that they wish to stop their opioid therapy if they experience adverse effects. **(Continue – inside)**

INSIDE: *"Hui Ho 'omaikai'i Ika Poe O Hawai'i"*

COVER STORY: "Practice Pointers" – Continue

Salsitz notes that, on a physiologic level, substance-addicted persons overreact to stress. Although, MMT generally stabilizes the stress-response system, methadone still maybe metabolized faster during times of increased stress.

Also, since methadone fills opioid receptors in the brain and replaces the natural endogenous opioid system, the body may not produce sufficient endorphins to comfortably handle added stress. Hence, the patient may feel drug hunger or withdrawal symptoms that can be resolved by an increased methadone dose.

Salsitz believes a dose increase in this circumstance should be viewed as more than just a temporary fix. For one thing, the effect is not immediate; it will take about five days to achieve a steady-state blood level at the new dose.

In some cases, a dose increase is all that is required for the patient. For others, additional counseling and support services might be appropriate. However, Salsitz stresses, a request for a dose increase does not necessarily indicate any behavioral instability and patients should not be penalized, such as being denied earned privileges or take home doses.

Innate Senses

'I put myself in the patient's position," Salsitz says. "Most people have requested a new medication, or extra medicine, at some time in their lives to deal with unusual stress or physical symptoms. So, what's wrong with an MMT patient requesting extra methadone?

He believes that long-term patients develop an innate sense of when an increased methadone dose will help them continue to feel and function normally. For example, he had one patient whose sister committed suicide. "This was very traumatic for the patient," Salsitz recalls. "She had been stable on 80 mg/day of methadone but immediately asked for an increase to 100 mg/day, which is where she comfortably stayed."

Flexible Options

Causes other than stress also need consideration. For various reasons – such as, changes in medication, lifestyle, or diet – a patient may start to metabolize methadone differently. The person may complain primarily of problems sleeping or awakening too early without feeling rested.

Increasing the methadone dose in response to these symptoms might not be the best solution. It could be better for the patient to take most of the dose in the morning as usual and the remainder in the evening just before retiring.

Salsitz also has observed that, in those persons who become fatigued during the afternoon, taking part of the methadone dose at that time perks them up. He acknowledges that this is counterintuitive, since one might expect that methadone itself would be sedating. The unexpected refreshing effect might have something to do with substituting for an endorphin boost, much like the "second wind" that many people get late in the day by having a candy bar or cup of coffee.

The important thing to Salsitz is that patients should have the option while remaining at the same total daily methadone dose, of experimenting with taking different proportions during the day. This is done with many other medications, to even-out drug actions or to minimize side effects.

Admittedly, this sort of dosing flexibility becomes challenging for those patients who must attend the MMT clinic daily to take their full methadone dose under observation. Yet, it is something clinic staff should keep in mind as a goal to help overcome unexplained situational abstinence syndrome.

In terms of how methadone is metabolized and works in the body, there is no reason that once-daily dosing would be best or optimal for every patient.

Compassionate Attitudes

Salsitz concedes that his approach, based on his experiences in office-based methadone medical maintenance, applies to previously stable, treatment-compliant patients. These patients are viewed and treated as any other persons with chronic illness who have valid reasons behind their requests for additional medication. "Perhaps, extra methadone isn't always the answer, but there is definitely something in these persons' lives needing attention," he says.

Regrettably, federal regulations in the past have not always fostered favorable doctor-patient relationships, he notes, especially when it comes to methadone prescribing. Even with the new, enlightened regulatory approach, there is still the question of whether MMT medical staff will take the time to be more understanding and flexible in their approaches.

Still, the average clinic can indeed gravitate toward more of a medical maintenance model, Salsitz believes. "This may not be appropriate for every patient, but a lot of it has to do with a compassionate attitude emphasizing individualized patient care." It is totally in keeping with the spirit of the new federal regulations. *(AT Forum; 5/06')*

COVER STORY: "Patient Safety/ Opioid Tapering" - Continue

Opioid rotation is an option; however, patients may be wary to try another agent or may experience intolerable adverse effects with certain chemical classes of opioids. Their pain may not be opioid-responsive, their underlying disease process may have improved as a result of surgery or other interventions, or despite increasing their dose at regular intervals, an adequate pain response may not be realized.

Tapering off opioids (often called detoxification or "detox") may be done within a chemical-dependency treatment setting, specialty clinic, or primary care practice. Protocols vary between different institutions and outpatient centers.

The duration of the taper depends on its complexity and the patient's needs. The universal goal is to taper as quickly as the patient's physiologic condition and psychological status allow. The presence of multiple comorbidities, polysubstance abuse, female gender, and older age are among factors increasing the difficulty of tapering and tend to lengthen its duration.

Patients with a long history of taking chronic opioids or any centrally acting medication involving receptor pharmacology (e.g., dopamine agonists, SSRIs) are more likely to experience withdrawal during a taper that is too rapid and, therefore, may require a longer taper period to avoid such symptoms *(in some individuals…not all)*. Some patients may have a great deal of anxiety about the potential for increased pain or experiencing withdrawal symptoms. In all cases, it is important to make decisions about tapering therapy on an individual basis.

Agents Used for Opioid Tapering

Depending on the situation, several options for tapering agents are available. The same opioid medication the patient has been taking may be used. This can be accomplished even with short-acting agents. The average daily dose should be spaced evenly throughout the day (and "pm" doses eliminated), usually with a frequency of every 4 or 6 hours. Once the patient has been stabilized on a scheduled dosing frequency, the tapering regimen may be implemented.

(Continue next page)

(COVER STORY: "Patient Safety/ Opioid Tapering" – Continue)

Short-acting agents may be replaced with another medication with a long half-life, such as methadone, or an extended release product such as MS Contin® or OxyContin®. Many programs use methadone, as it is less likely to produce euphoria and is inexpensive compared with the other long-acting agents.

Usually after a dosing conversion has been completed, a "test dose" or "test regimen" will be given with close monitoring. If the dose of the long-acting agent is too low, the patient may develop withdrawal symptoms; however, if the dose is too high, the patient may develop sedation. During the first week, the dose of the long-acting agent should be adjusted to control any withdrawal symptoms. After the patient has been stabilized, the tapering regimen may be implemented.

Individual patients may have differing responses to the tapering regimen chosen. As noted above, for those who have been on long-term opioid therapy, there may be fear and anxiety about reducing and/or eliminating their opioid medication. Or, patients may be concerned about the recurrence or worsening of pain. They also may be concerned about developing withdrawal symptoms.

Typically, the last stage of tapering is the most difficult. The body adapts fairly well to the proportional dosage reduction to a point, and then (at less than 30-45 mg of opioid/day) the body cannot adapt as well to the changes in concentration and receptor activity, which precipitates withdrawal if the tapering regimen is not slowed.

Advising Patients on Emergency Tapering

Following the Katrina Hurricane in 2005, the National Pain Foundation offered some recommendations for what patients can do when all access to continuing pain medications is unexpectedly cut off, as during an emergency or other crisis. These are adapted below, and a version of this might be provided to patients whenever chronic opioid analgesics are prescribed. *(Pain Treatment Topics, Vol. 1, No. 1)*

Patient Instructions – Stopping Opioid Painkillers in an Emergency

If you are unable to refill or get your opioid medications, symptoms of withdrawal will vary depending on how long you were on the opioid medication and what type you were taking. People taking morphine, hydromorphone, or oxycodone may experience withdrawal symptoms within 6 to 12 hours of the last dose. Typically, withdrawal from morphine takes 5 to 10 days while withdrawal from methadone or other long-acting opioids takes longer.

Ideally, discontinuing the medication would be a slow tapering process under the care of a physician or other appropriate medical provider. If this cannot be accomplished, it is important to make an effort to taper the dose on your own as slowly as possible.

The best way to avoid serious withdrawal symptoms is to reduce the amount of medication you are taking or how often you are taking it before you run out. * "*Withdrawal symptoms from opioids can be alleviated by over the counter (OTC) medications such as ibuprofen (for aches, pains, and chills and Imodium (for diarrhea)."*

If you are taking any of the extended release versions of opioids, such as OxyContin or Kadian or fentanyl patches, do not tamper with them in any way. Breaking or opening these capsules, or cutting patches, can release the entire dose at once, causing overdose and possible death. Instead, take the whole tablet or capsule or use the whole patch, but take or use the medication less often to reduce the dosage.

Drink a lot of fluid, try to stay calm, and keep reassuring yourself that any withdrawal reaction will pass and you will eventually feel better. One of the symptoms during opioid withdrawal is a state of sensitized pain, meaning your pain may feel more intense or severe. This also will pass with time.

Remember: Always seek professional healthcare assistance as soon as you can – if possible, before running out of medication.

National Drunk and Drugged Driving Prevention Month, 2006

Each year, thousands of Americans lose their lives in accidents involving drunk and drugged driving. During National Drunk and Drugged Driving Prevention Month, we continue our efforts to promote awareness of the dangers of impaired driving and encourage fellow citizens to never drive under the influence of alcohol or drugs.

All Americans can play an important role in preventing drunk and drugged driving. Family members can discuss the dangers of impaired driving; businesses, schools, and organizations in our communities can help spread the message of awareness; and individuals can help protect family and friends by identifying a designated driver. During the holiday season, it is especially important to encourage responsible driving and to help ensure the safety of friends and loved ones.

Be committed to saving lives by stopping drunk and drugged drivers before they put themselves and others at risk. The Department of Transportation's National Highway Traffic Safety Administration has partnered with State and local law enforcement agencies to carry out the campaign, "Drunk Driving. Over the Limit. Under Arrest." This program aims to keep impaired drivers off our Nation's roads by creating new public education programs and toughening enforcement. The Office of National Drug Control Policy works to warn young drivers and their parents about the dangers of driving under the influence of drugs.

Every person has a responsibility to drive free of alcohol and drugs and to insist that friends and family do the same. By helping fight drunk and drugged driving, Americans everywhere can save lives and send a strong message that driving under the influence is not acceptable. (*December 1, 2006; WhiteHouse)*

HAVE A SAFE & HAPPY HOLIDAY SEASON!

Fates of Buprenorphine, MMT Intertwined

For decades, there has been a desire to close the gap between the need for effective opioid-addiction treatment and its availability. The approval of buprenorphine maintenance therapy in 2002 for this purpose, joining methadone maintenance treatment (MMT) , was greeted with great optimism in some quarters and trepidation in others.

If MMT's past is predictive of buprenorphine's future, there may be much to worry about. Indeed, the fates of both modalities for treating opioid addiction may be intertwined in ways that few suspect.

Expanded Treatment Needed

A recent review by Robert G. Newman, MD, (1) explored linkages between the past growth of MMT and the present status of buprenorphine maintenance therapy. Newman – director of the Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center, New York – helped pioneer the extensive adoption of MMT in New York City.

More than 30 years ago, in the early 1970s, MMT expanded swiftly and was declared a "success," Newman recalls. Yet, growth of both MMT clinics and numbers of patients treated quickly stagnated; then as now, MMT is available to only about 1 in 5 persons with the disease of heroin addiction.

He notes that about 36,000 patients in New York City receive MMT today, out of an estimated 200,000 heroin-dependent persons; compared with 34,000 MMT patients in 1974. However, today there also is the threat of HIV/AIDS and thousands of additional persons addicted to opioid analgesics, so the need for more treatment options has never been greater.

Buprenorphine may help. This medication, an effective analgesic (as is methadone), has been in use since the late 1970s. During 2 decades of clinical research buprenorphine maintenance therapy was demonstrated as helpful for treating opioid addiction; or, at least as effective as methadone, in some patients and in certain circumstances.

Unfortunately, controlled clinical trials often fail to clearly define exactly which patients can benefit most from a therapy when it comes to everyday medical practice in diverse settings. This is a concern with buprenorphine, and only time will tell where, when, and in whom it works best.

Impressive Outcomes Data

Last spring, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) released some impressive statistics regarding the adoption of buprenorphine. (2) During the early years following its approval for addiction therapy in October 2002 the number of sites and physicians offering the treatment grew rapidly, as expected.

By the beginning of 2005 there were about 2,800 physicians approved to use buprenorphine (received waivers), half of whom had not previously provided therapy for opioid addiction, and two-thirds were prescribing the medication. The largest numbers of those prescribing buprenorphine, nearly 1,200, were in individual private practices. Fewer than 400 were in existing opioid-addiction treatment settings. (2)
By March 2005, SAMHSA estimated that a cumulative total of 104,600 patients had received buprenorphine since its approval; about a third received the medication as part of an opioid detoxification regimen rather then ongoing maintenance. Roughly 60% of all patients were primarily addicted to or abused non-heroin opioids and a third of them suffered from chronic pain conditions. (2) This is important, because there are significant numbers of pain patients abusing opioid analgesics and they may represent a major subpopulation who might benefit from buprenorphine.

While some may question the data, 6-month treatment outcomes reported by SAMHSA are noteworthy. During the 30 days prior to being surveyed, about 60% of patients self-reported abstinence from all substances of abuse and 80% were abstinent from all opioids (except prescribed buprenorphine). At the same time, retention rates were 71% to 77% (depending on primary substance of prior abuse), with reported increases in employment and decreased criminality. (2)

Few of the prescribing physicians believed their patients would have sought MMT for their addiction and most perceived buprenorphine to be most effective during longer-term treatment. Buprenorphine appeared to be somewhat more effective for patients primarily addicted to prescription opioids rather then heroin. (2)

Relaxed Regulations

At least some of buprenorphine's success, and its potential for failure, hinges on relaxed federal regulations. Newman commented that, since the beginning of MMT, individualized care and comprehensive ancillary services have been recognized as essential components to ensure addiction recovery, which requires intensive staff training and extended time in treatment. (1)

Although the regulatory demands placed on MMT clinics are undiminished to this day, any physician can become certified to prescribe buprenophine for addiction after only 8 hours of training (now even available online). And, addiction counseling and ancillary services are not mandated components of buprenorphine therapy.

Buprenorphine can be prescribed for a full month, and in some states the prescriptions are refillable without physician contact, Newman notes. (1) Indeed, SAMHSA's survey data show that during the first month of buprenorphine therapy nearly three-quarters of patients see the prescribing physician 3 or fewer times; more than a third go only once. Forty-one percent receive no counseling at all, and the majority of patients (about 70%) receive 0 to 4 counseling sessions. (2)

On the other hand, entry-level MMT patients must attend a clinic at least 6 days per week for observed dosing. Along with that, they must attend counseling sessions and have drug monitoring.

It seems reasonable that buprenorphine therapy would appeal to many opioid-addicted persons, if they can afford it. However, its long-term effectiveness as an addiction treatment might be in doubt, and Newman questions whether this is good medical practice for dealing with a chronic, relapsing disease to begin with. (1) Still, in balance, the SAMHSA survey data (2) demonstrate positive outcomes for buprenorphine therapy; at least relatively short-term.

CONTINUE NEXT PAGE

Formidable Barriers

Despite the 'conveniences' of buprenorphine therapy, Newman believes there are formidable barriers to its widespread acceptance. "We can hardly expect physicians, patients or the public at large to embrace treatment with one medication (buprenorphine), when Government itself continues to reflect and reinforce the stigma toward treatment with another medication 9methadone) for the same patients and the same disease," he writes.

Newman expresses the perspective that the overabundance of regulations and prejudices surrounding MMT serve to taint the whole field of opioid-addiction treatment, and the stigma naturally carries over to buprenorphine. An implication is that, "mainstream medicine" would largely stay away and those providers who do become involved in prescribing buprenorphine must consider the discomforting possibility that at some point in time their practices may come under government-imposed restrictions similar to those for MMT. Especially, if buprenorphine fails to deliver on its promised success.

Therefore, the concern should not be that buprenorphine will draw patients away from MMT – for there are plenty of patients in need of treatment. The real danger is that, after all the promotion and government-sponsored support, if buprenorphine maintenance therapy fails it will reflect negatively on opioid-addiction treatment in general, including a further stigmatization of MMT. A jaded public and exasperated policy-makers may well turn their backs on treatment, as they have in the past, and refocus their attention on the criminalization of opioid addiction.

[1] Newman RG. Expansion of opiate agonist treatment: an historical perspective. Harm Red J. 2006; 3:20 +. Available online at: http://dx.doi.org/10.1186/1477-7517-3-20. Access checked 8/26/06.

[2] Stanton A, et al. Expanding treatment of opioid dependence: Initial physician and patient experiences with the adoption of buprenorphine. Presentation at American Society of Addiction Medicine, Annual Conference, May 5, 2006. Available online at: http://buprenorphine.samhsa.gov/ASAM_06_Final_Results.pdf. Access checked 8/26/06.

DASH GROUPS

Tuesday

"ACUPUNCTURE"
Cost: $5.00
Time: 7:00 – 8:00 AM.

Wednesday

"WOMEN'S GROUP"
9:00 – 11:00 AM.
W/Jocelyn

Thursday

"MEN'S GROUP"
9:00 – 11:00 A.M.
W/Adam

Friday

Methadone Support Group
(MSG)
9:00 – 10:00 AM.
W/Jocelyn

Starting Jan. 25 (Thurs.)
"COPING SKILLS"
W/Dr. Vivian

This group is limited to 10 persons; you need to be referred by your counselor.

New Years Celebration & Farewell to Jen Party!

If you have not heard by now, "Jen" is leaving DASH; her last day will be this coming Friday, January 12. DASH is having a "New Years Celebration" and "Farewell PARTY for Jen" this Friday! Come and join the celebration, and show your love for a woman who has helped many Haumana since she joined the DASH team. Jen will be returning to her home and family in the Big Island. However, she will still be a part of the DASH family, working at the DASH Clinic in Hilo! Much love from all of us here at the Honolulu Clinic….Jen, you will definitely be missed!

DATE: Friday, January 12, 2007
TIME: 6:00 - 11:30 AM.
WHERE: Conference Room

(Mandatory)
"ORIENTATION GROUP"

WHEN: Tuesday, January 9, 2007
TIME: 10:00 – 11:00 AM.

(All Haumana that need to attend this group, there is a list in the waiting room with your names on it)

Thank you!

NEW DOSING HOURS:

Weekdays & Holidays

Effective Jan. 2, 2007
5:30 – 11:30 AM.

Dosing Nurse will take break at:
7:45 – and 9:45 AM.

Weekend Hours

Open Saturday's ONLY
Effective Jan. 2, 2007
6:30 – 11:00 AM.

Closed on Sunday's
Effective Jan. 2, 2007

(We are currently working on getting approval to be closed on all Federal holidays also.)

"HIV, HEPATITIS, & T.B." Group

(There will be two Groups:)

Friday, January 5, 2007
AND
Thursday, January 25, 2007

ATTENTION:

DASH will take adolescents with parental consent into treatment.

Please call DASH for more information:
(808)-538-0704