Pharmacotherapy and Narcotic Dependency: Best and Promising Practices

September 9–10, 2002

Sheraton Bucks County Hotel
Langhorne, Pennsylvania

Cosponsored by
The Center for Substance Abuse Treatment (CSAT) and
The Bucks County Drug and Alcohol Commission, Inc.

Agenda

Monday, September 9, 2002

8:00–9:00 a.m.	**REGISTRATION AND CONTINENTAL BREAKFAST**
9:00–9:45 a.m.	***Welcoming Remarks***
	Welcome to Bucks County—Charles H. Martin, Bucks County Commissioner and Sandra A. Miller, Bucks County Commissioner
	Conference Challenges—Margaret E. Hanna, M.Ed., Executive Director, Bucks County Drug and Alcohol Commission, Inc. (BCDAC) and Mark Morgan, Mental Health Program Director, Bucks County–Creating Satisfaction Together, Inc., and BCDAC Board Member
	Remarks—Gene R. Boyle, M.A., Director, Pennsylvania Department of Health, Bureau of Drug and Alcohol Programs; Nicholas Reuter, Senior Public Health Analyst, Center for Substance Abuse Treatment, Division of Pharmacological Therapy; Steven J. Karp, D.O., Chief Psychiatric Officer, Pennsylvania Department of Public Welfare; and William R. Dubin, M.D., Medical Director, Bucks County Behavioral Health System, and Professor of Psychiatry, Temple University School of Medicine
9:45–10:45 a.m.	***Addictionology and Opioid Dependency***—Trusandra E. Taylor, M.D., Medical Director, Montgomery County Methadone Center, Norristown, Pennsylvania
10:45–11:00 a.m.	**BREAK**
11:00 a.m.–12:00 p.m.	***Pharmacotherapy and Its Role in Opioid Dependency Treatment***—Mark W. Parrino, M.P.A., President, American Association for the Treatment of Opioid Dependence, Inc., New York, New York
12:00–1:00 p.m.	**LUNCH**—*Sponsored by Megellan Behavioral Health of PA, Newtown, Pennsylvania*

1:00–2:00 p.m.	***Treating the Pharmacotherapy Client in a "Drug-Free" Facility: A Panel Discussion***—with Linda Barry, M.Ed., LCDS, Program Director, SSTAR-SSTARBIRTH, Cranston, Rhode Island; David Spencer, M.P.A., M.B.A., Executive Director, TRI-HAB, Inc., A Gateway Healthcare Provider, Woonsocket, Rhode Island; and Maria T. Wensus, LSW, Program Coordinator, Aldie Counseling Center, Pharmacotherapy Program, Doylestown, Pennsylvania; and moderated by Sharon A. Morello, B.S.N., RN, Administrator of Substance Abuse Treatment Services, Rhode Island Department of Mental Health, Retardation and Hospitals, Division of Behavioral Healthcare
2:00–2:15 p.m.	***Questions and Answers***
2:15–2:30 p.m.	**BREAK**
2:30–4:25 p.m.	***Treatment and the Justice System: A Critical Partnership*** *Perspectives on Challenges for the Treatment System: A Panel Discussion*—with Robert E. Cosner, LSW, Director, Bucks County Children and Youth Social Services Agency; Francis V. Crumley, M.S.W., Chief Adult Probation and Parole Officer, Bucks County Adult Probation and Parole Department; Richard M. Notaro, Supervisor of Drug and Alcohol and Intensive Aftercare, Bucks County Juvenile Probation Department; and Hon. John J. Rufe, Judge, Court of Common Pleas of Bucks County; and moderated by Robert E. Kelsey, M.Div., Deputy Chief Adult Probation and Parole Officer, Bucks County Adult Probation and Parole Department *Criminality and Substance Abuse Treatment*—Harris Gubernick, M.A., Director, Bucks County Department of Corrections *One Model of the Criminal Justice and Treatment Partnership*—Hon. Henry F. Weber, District Court Judge, Jefferson District Court, Louisville, Kentucky and introduced by Hon. John J. Rufe
4:25–4:30 p.m.	***Wrap-up***—Margaret E. Hanna, M.Ed.
4:30 p.m.	**ADJOURN**

Tuesday, September 10, 2002

8:00–9:00 a.m.	**REGISTRATION AND CONTINENTAL BREAKFAST**
9:00–9:15 a.m.	***Welcoming Remarks***
	Welcome—Michael G. Fitzpatrick, Esq., Chairman, Bucks County Commissioners
	Conference Challenges Revisited—Diane W. Rosati, M.A., Associate Director, BCDAC and Hon. Gene DiGirolamo (R), State Representative, Pennsylvania House of Representatives
9:15–10:30 a.m.	***Co-Occurring Perspectives: The Mentally Ill Opiate-Dependent Client***—Bert Pepper, M.D., M.S., Clinical Professor of Psychiatry, New York University School of Medicine, Member of the National Mental Health Association's Substance Abuse Task Force, and Founder and Executive Director, The Information Exchange, Inc., New City, New York
10:30–10:45 a.m.	**BREAK**
10:45–11:30 a.m.	***Co-Occurring Perspectives: The Mentally Ill Opiate-Dependent Client (Cont.)***—Bert Pepper, M.D., M.S.
11:30 a.m.–12:00 p.m.	***Questions and Answers***
12:00–1:00 p.m.	**LUNCH**
1:00–2:00 p.m.	***Creating the Best Climate for Recovery: A Work in Progress***—with Deborah Atkinson, Bucks County Behavioral Health Consumer Advocate, Bucks County Behavioral Health Systems/Reach Out Foundation of Bucks County; Sharon Brass-Corey, J.D., Board of Directors, Bucks County Council on Alcoholism and Drug Dependence, Inc., and Member of PRO-ACT; James P. Connolly, Director and Methadone Patient Advocate, Pennsylvania Chapter of the National Alliance of Methadone Advocates; Kate Hodder, B.S., Manager, Bucks County Department of Corrections, Women's Community Corrections Center; Robert E. Kelsey, M.Div.; and Kathy Sharp, Executive Director, Reach Out Foundation, Morrisville, Pennsylvania; and moderated by Dorothy J. Farr, LSW, LADC, Clinical Director, BCDAC

About the Conference

The addiction field entered the 21st century riding atop a crest of advances in how addictive disorders are treated. Treatment of opioid dependence has been at the forefront of the wave of these advances—science and clinical practice have combined to shape our understanding and treatment of opioid dependence. Treatment approaches and settings, pharmacologic interventions, and public policy have all evolved and expanded our options for addressing heroin and other forms of opioid dependency.

The Center for Substance Abuse Treatment (CSAT) and the Bucks County Drug and Alcohol Commission, Inc., have been longstanding partners in efforts to address opioid problems in the Bucks County area. This 2-day conference continues our efforts to seek out and promote *Best and Promising Practices* by providing up-to-date information on:

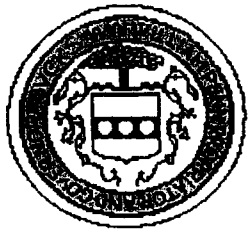
- Addictionology as it relates to opioid use, abuse, and dependence
- Opioid dependency with co-occurring substance use disorders and/or psychiatric and/or medical conditions
- Best practice standards for treatment, including methadone maintenance in combination with other levels of care/approaches

Tuesday, September 10, 2002, continued

2:00–2:30 p.m.	***Harm Reduction: Not Without Social Policy and Disease Management Changes***—Jeffrey J. Kegley, M.S.W., Executive Vice President and COO, Advanced Treatment Systems, Inc., Kennett Square, Pennsylvania
2:30–2:45 p.m.	**BREAK**
2:45–3:15 p.m.	***Harm Reduction: Not Without Social Policy and Disease Management Changes (Cont.)***—Jeffrey J. Kegley, M.S.W., and consumers
3:15–4:25 p.m.	***Where Do We Go From Here: The Challenge for Treatment Professionals***—Peter A. DeMaria, Jr., M.D., FASAM, Associate Professor of Psychiatry and Human Behavior, Jefferson Medical College, and Medical Director, Narcotic Addict Rehabilitation Program of Thomas Jefferson University, Philadelphia, Pennsylvania and Mark W. Parrino, M.P.A.
4:25–4:30 p.m.	***Closing***—Diane W. Rosati, M.A.
4:30 p.m.	**ADJOURN**

Please drop off evaluation and CEU forms at the registration desk at the end of the day!

CSAT
Center for Substance Abuse Treatment
SAMHSA
Substance Abuse and Mental Health
Services Administration



BIOGRAPHICAL SKETCHES

Pharmacotherapy and Narcotic Dependency: Best and Promising Practices

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ABOUT THE PRESENTERS

Deborah Atkinson is the Bucks County Behavioral Health Consumer Advocate for the Bucks County Behavioral Health Systems/Reach Out Foundation of Bucks County. In this groundbreaking position, her mission is to help behavioral health consumers become empowered. Ms. Atkinson is a member of the Bucks County Crisis Team, the Keystone Crisis Intervention Team for the State of Pennsylvania, and the National Organization of Victim Assistance. She also facilitates a meeting for women with co-occurring mental health and addictive disorders at the Doylestown Correctional Facility, and she is on the Advisory Board for the Compeer Program, which is a component of the Mental Health Association of Southeastern Pennsylvania.

Linda Barry, M.Ed., LCDS, has been the Program Director of SSTAR-SSTARBIRTH in Cranston, Rhode Island since 1993. SSTARBIRTH serves pregnant and postpartum women with alcohol and other drug (AOD) problems and their children. Ms. Barry has more than 20 years of experience as a clinician, program director, and educator, working with heroin addicts and others with AOD problems in both outpatient and residential settings. She spent much of this time developing and managing programs for women. She has also served on the faculty of both the Rutgers Summer School of Alcohol Studies and the New England School of Alcohol Studies. Ms. Barry earned her M.Ed. from Cambridge College; she is a Rhode Island Licensed Chemical Dependency Supervisor; and she is the current President of Rhode Island's Drug and Alcohol Treatment Association.

Gene R. Boyle, M.A., is Director of the Pennsylvania Department of Health's Bureau of Drug and Alcohol Programs (BDAP). In this capacity, Mr. Boyle oversees planning, coordination, and direction of the statewide AOD service delivery system, including $120 million in service contracts to 49 single county authorities (SCAs). He is himself a former Executive Director of an SCA, the Carbon/Monroe/Pike Drug and Alcohol Commission. Mr. Boyle is a graduate of East Stroudsburg University.

Sharon Brass-Corey, J.D., is on the Board of Directors of the Bucks County Council on Alcoholism and Drug Dependence (BCCADD) and member of PRO-ACT's Public Policy Committee. Ms. Brass-Corey was instrumental in organizing a public hearing on Act 106 and has testified at both public and State budget hearings on the act. She began her professional career as an attorney and is now a community volunteer. In addition to her work with BCCADD and PRO-ACT, she volunteers with the Handicap Olympics-Family Services Buddy Program and Pennsylvania Lawyers Concerned for Lawyers. Ms. Brass-Corey is a graduate of Temple University and Villanova University Law School.

James P. Connolly is the Pennsylvania Chapter Director and a Regional Director of the National Alliance of Methadone Advocates (NAMA). Mr. Connolly is also the NAMA representative on the Center for Substance Abuse Treatment (CSAT) Methadone Patient Support and Community Education Project. As a methadone patient advocate, he volunteers his time to help eliminate discrimination against methadone patients and to help create a more positive image of methadone maintenance treatment. Mr. Connolly is also a participant in the Partners Against Pain Program, and he recently founded Pennsylvania Pain Patient Advocates, a branch of a national network that helps pain patients locate compassionate doctors for appropriate treatment.

Robert E. Cosner, LSW, is the Director of the Bucks County Children and Youth Social Services Agency.

Francis V. Crumley, M.S.W., is the Chief Adult Probation and Parole Officer of the Bucks County Adult Probation and Parole Department.

Peter A. DeMaria, Jr., M.D., FASAM, is an Associate Professor of Psychiatry and Human Behavior at the Jefferson Medical College in Philadelphia, Pennsylvania. Dr. DeMaria also holds several other posts at Thomas Jefferson University, including Medical Director of the Narcotic Addict Rehabilitation Program, Psychiatric Consultant with the Family Center Program, and Lecturer in the College of Health Professions. With more than 16 years experience in addictive medicine, he has published, taught, and presented extensively, and he has been a member of several university, State, national, and professional committees and task forces on AOD issues. Dr. DeMaria received his B.A. from Lafayette College and his M.D. from Jefferson Medical College. He is board-certified by the American Board of Psychiatry and Neurology, Inc. (ABPN); has a Certificate of Added Qualifications in Addiction Psychiatry from ABPN; has addiction certification from both the American Society of Addiction Medicine (ASAM) and the Medical Review Officer Certification Council; is a Fellow of the American Society of Addiction Medicine (FASAM); and is a 2001 winner of the Nyswander-Dole Award ("The Marie Award") from the American Methadone Treatment Association (now known as the American Association for the Treatment of Opioid Dependence, Inc.).

Hon. Gene DiGirolamo (R), a lifelong resident of Bensalem Township, has been the State Representative in Pennsylvania's 18th Legislative District since 1995. He is currently the Secretary of the State House of Representatives Appropriations Committee and serves on several other legislative committees. Representative DiGirolamo attended Delaware Valley College and Holy Family College. He has a longstanding history as a community volunteer and was the 1993 recipient of the Bucks County Drug and Alcohol Commission, Inc., Prevention Volunteer of the Year Award.

William R. Dubin, M.D., is the Medical Director of the Bucks County Behavioral Health System and a Professor of Psychiatry at the Temple University School of Medicine.

Dorothy J. Farr, LSW, LADC, is the Clinical Director of the Bucks County Drug and Alcohol Commission, Inc. (BCDAC). Ms. Farr has more than 27 years experience as a program director and clinician in public and private, residential and outpatient settings serving populations such as women with AOD problems and their children; adults and adolescents with co-occurring mental health and addictive disorders; and criminal offenders. She has served on several national and statewide committees addressing co-occurring disorders. Ms. Farr received her undergraduate degree in Social Work from Salem State College and her graduate degree from Indiana University/Perdue University School of Social Work. She is also a Pennsylvania Licensed Clinical Social Worker and State of Maine Licensed Alcohol and Drug Counselor.

Michael G. Fitzpatrick, Esq., is Chairman of the Bucks County Commissioners.

Harris Gubernick, M.A., is the Director of Corrections in the Bucks County Department of Corrections. For the past 25 years, Mr. Gubernick has delivered and overseen services for offender and AOD patient populations. His 17-year tenure with the Department of Corrections has included posts as Drug and Alcohol Treatment Section Supervisor, Work Release Manager, Deputy Superintendent, Superintendent of Community Corrections, and Deputy Director. Prior to joining the department, Mr. Gubernick worked in a variety of clinical and management positions serving a range of adult and youth populations receiving AOD services. Mr. Gubernick earned his B.A. in Psychology from Temple University and his M.A. in Industrial Counseling and Program Design from Lesley College.

Margaret E. Hanna, M.Ed., has been the Executive Director of the Bucks County Drug and Alcohol Commission, Inc. (BCDAC) for the past 20 years. Ms. Hanna is also the Deputy Project Director for the Bucks County Behavioral Health System, the lead entity for the county's Medicaid managed care program. She has more than 30 years experience in behavioral health management in the public and private sectors and regularly consults, trains, and serves on many boards at the local, State, and national levels. For instance, she is currently on the Board of Directors of the National Association of County Behavioral Health Directors, an affiliate of the National Association of Counties; she is on the Executive Committee of the Pennsylvania Association of County Drug and Alcohol Administrators; and she serves on the Board of Directors of the Bucks County Association for Corrections and Rehabilitation, Inc. She received her B.S. in Rehabilitation Counseling and her M.Ed. in Counselor Education from The Pennsylvania State University.

Kate Hodder, B.S., is the Manager of the Bucks County Department of Corrections' Women's Community Corrections Center. Ms. Hodder has 8 years of experience working in corrections and has held posts as Case Manager and the Drug and Alcohol Supervisor within the Department of Corrections. She was part of the team that developed the Bucks County Managed Behavioral Health Care System, and she served as Care Manager and Supervisor of Care Management for the Bucks County Drug and Alcohol Commission, Inc. for approximately 5 years.

Steven J. Karp, D.O., is the Chief Psychiatric Officer for the Pennsylvania Department of Public Welfare.

Jeffrey J. Kegley, M.S.W., is the Executive Vice President and Chief Operating Officer of Advanced Treatment Systems, Inc., in Kennett Square, Pennsylvania. Mr. Kegley has more than 30 years of experience in the AOD field as a practitioner, clinical supervisor, executive director, and corporate vice president. Mr. Kegley received his M.S.W. from The George Warren Brown School of Social Work at Washington University.

Robert E. Kelsey, M.Div., is the Deputy Chief Adult Probation and Parole Officer in the Bucks County Adult Probation and Parole Department. For nearly 20 years, Mr. Kelsey has held several management positions within the department. He is also active on several committees and boards, including serving as current Chair of the Bucks County Drug and Alcohol Commission, Inc.; Executive Committee member of the Pennsylvania Association on Probation, Parole, and Corrections; and on the Steering Committee of the Bucks County Forensic Mental Health Panel. Mr. Kelsey received his B.S. in Business Education from Bloomsburg State College and his M.Div. from the Christian Theological Seminary.

Charles H. Martin is a Bucks County Commissioner.

Sandra A. Miller is a Bucks County Commissioner.

Sharon A. Morello, B.S.N., RN, is the Administrator of Substance Abuse Treatment Services in the Rhode Island Department of Mental Health, Retardation and Hospitals' Division of Behavioral Healthcare. In addition to primary care nursing positions, Ms. Morello's 26-year career includes extensive work in AOD nursing, management, and quality improvement at the State and program levels overseeing and delivering methadone maintenance, co-occurring disorders, and detoxification services. She presents, writes, and consults regularly on AOD-related issues, including providing technical assistance to methadone programs to prepare them for certification surveys by CARF–The Rehabilitation Accreditation Commission. Ms. Morello received her B.S.N. from Rhode Island College.

Mark Morgan is currently the Mental Health Program Director of the Bucks County Creating Satisfaction Together, Inc. (BC-CST). BC-CST assesses consumer satisfaction in Bucks County and promotes consumers' rights to self determination. Mr. Morgan is a board member of the Reach Out Foundation of Bucks County, a nonprofit organization run by and for behavioral healthcare consumers. He is also on the Board of Directors of the Bucks County Drug and Alcohol Commission, Inc., the Pennsylvania Mental Health Consumers Association, and the Penndel Mental Health Center. Mr. Morgan is a strong advocate of "Double Trouble" support groups for individuals with co-occurring mental health and AOD issues.

Richard M. Notaro is the Supervisor of Drug and Alcohol and Intensive Aftercare in the Bucks County Juvenile Probation Department. Mr. Notaro has held several positions affecting drug-involved youth during his more than 20-year career with the department and in his roles as a police officer and childcare worker prior to joining the department. He is also extremely active on professional, State, and community-based boards, associations, and commissions addressing troubled youth, including those involved in alcohol and other drugs. Mr. Notaro received his B.S. in Law Enforcement and Corrections from The Pennsylvania State University.

Mark W. Parrino, M.P.A., is the President of the American Association for the Treatment of Opioid Dependence, Inc. (AATOD), formerly the American Methadone Treatment Association, Inc. (AMTA). In this role, Mr. Parrino directs interstate organizational, legislative, and conference activities for opioid treatment providers, and he serves as the field's liaison to the White House Office of National Drug Control Policy, congressional committees, Federal and State agencies, and national associations. He has been involved in healthcare and AOD service delivery and management since 1974. During this time, he has consulted, presented, and written extensively on opioid treatment. He has also served on several local, State, and national task forces and commissions addressing opioid treatment such as serving as Chairman of the Consensus Panel on CSAT's TIP #1: State Methadone Treatment Guidelines; serving as Chairman of the New York State Committee of Methadone Program Administrators; and being a member of the Task Force to Consolidate the New York State Division of Substance Abuse Services with the State Division of Alcoholism and Alcohol Abuse. Mr. Parrino received his B.A. in Psychology and his M.P.A. in Health Policy, Planning and Administration from New York University.

Bert Pepper, M.D., M.S., is the Founder and Executive Director of The Information Exchange, Inc. (TIE), New City, New York. TIE is a not-for-profit agency dedicated to improving treatment for mentally ill and emotionally troubled persons, especially those who also have AOD problems. Dr. Pepper also maintains a private psychiatric practice and is a Clinical Professor of Psychiatry at the New York University College of Medicine. During a career spanning more than 40 years, Dr. Pepper has delivered psychiatric services within public and private settings; he has served on faculties or been a lecturer at several leading medical schools; and he has held senior positions in the Maryland and New York State mental health agencies. Dr. Pepper has published widely and served on numerous local, State, and national committees, task forces, and boards, including his current membership on the National Mental Health Association's Substance Abuse Task Force. His numerous awards and honors include being listed among Who's Who in Medicine and Healthcare in 1997, being a 1996 recipient of the American Association for Psychosocial Rehabilitation Scientific Distinction Award, and being recognized by Woodward/White as one of the Best Doctors in America, Northeast Region, in 1996. Dr. Pepper earned his B.S. in Chemistry from the City College of New York, an M.S. in Community Psychiatry and Administrative Medicine from Columbia University of Public Health and Administrative Medicine, and his M.D. from the New York School of Medicine. He is certified in Psychiatry by the American Board of Psychiatry and Neurology.

Nicholas Reuter is a Senior Public Health Advisor in CSAT's Division of Pharmacologic Therapy (DPT). DPT is responsible for the Department of Health and Human Services' regulatory oversight of opioid treatment programs in the United States, including the certification of opioid treatment programs and the registration and training of physicians seeking to prescribe buprenorphine. During his tenure, Mr. Reuter has worked closely with the Food and Drug Administration on domestic and international drug control issues and opioid treatment regulation.

Hon. John J. Rufe has been a Judge with the Court of Common Pleas of Bucks County for the past 13 years. Before taking a seat on the bench, Judge Rufe practiced law for 24 years. He has held membership in several professional and community organizations and associations, including a term as president of the Bucks County Bar Association and membership on the Bucks County Mental Health/Mental Retardation Advisory Group. Among his many honors and awards, Judge Rufe was listed among Who's Who in American Law in 1977. Judge Rufe received his A.B. in History from Lafayette College and his L.L.B. from the Duke University Law School.

Diane W. Rosati, M.A., is the Associate Director of the Bucks County Drug and Alcohol Commission, Inc. In her more than 20 years in the AOD field, Ms. Rosati has held positions as a therapist, student assistance consultant, hotline coordinator, and prevention coordinator. During this time, she has garnered expertise in training, facilitation, and program development. Ms. Rosati holds an M.A. in Counseling Psychology.

Kathy Sharp is the Founder and Executive Director of the Reach Out Foundation of Bucks County. The Reach Out Foundation is a drop-in center for persons with mental health and AOD problems that opened 6 years ago. Ms. Sharp's efforts to help consumers with behavioral health issues began 11 years before she started Reach Out. She is also a member of the State Mental Health Planning Council and on the board of the Mental Health Association of Southeastern Pennsylvania.

David Spencer, M.P.A., M.B.A., is the Executive Director of Tri-Hab, Inc., in Woonsocket, Rhode Island and Vice President of Gateway Healthcare. Tri-Hab, which is an agency of Gateway Healthcare, offers a range of AOD outpatient, day treatment, residential, detoxification, crisis intervention, and employee assistance programming. In addition to overseeing provider treatment systems, Mr. Spencer's 24 years in the field have included administrative positions at corporate and State agency levels, including 10 years with the Rhode Island AOD agency. He has served on several State and local boards and committees addressing health and human service issues, including his current post as Vice President of the Rhode Island Drug and Alcohol Treatment Association. Mr. Spencer received a B.A. in Political Science from Rhode Island College, an M.P.A. from the University of Rhode Island School of Public Administration, and an M.B.A. from the Providence College School of Business.

Trusandra E. Taylor, M.D., is the Medical Director of the Montgomery County Methadone Center in Norristown, Pennsylvania and an attending physician for the Parkside Recovery Methadone Program in Philadelphia. Dr. Taylor previously served as Medical Director for Bowling Green Brandywine in Kennett Square and as Medical Director for Addiction Treatment Services for Community Behavioral Health, a public sector managed behavioral health care system in Philadelphia. She is an internist with more than 20 years of experience in all levels of AOD inpatient and outpatient care and has a special interest in treating addiction to heroin, other opioids, and tobacco. Dr. Taylor is on the consensus panels of several CSAT TIPs currently being revised, including TIP #1: State Methadone Treatment Guidelines. She is an American Association for the Treatment of Opioid Dependence, Inc. faculty member on pharmacology, and she is an ASAM board member and a board member of several other professional organizations. Dr. Taylor received her B.S. from Howard University and her M.D. from Hahnemann Medical College. She is also Certified in Addiction Medicine by ASAM.

Hon. Henry F. Weber has been a District Court Judge in the Jefferson District Court in Louisville, Kentucky since 1984. During this time, Judge Weber has been very active in drug courts—he started the Jefferson County Drug Court in 1993, the Juvenile Drug Court in 1997, and the Family Drug Court in 2001. The Family Drug Court handles cases of addicted mothers trying to regain custody of their children. He has also been very active on local, State, and national boards and committees, such as serving as Chair of the Education Committee for the National Association of Drug Court Professionals. Judge Weber received a B.A. in Political Science from the University of Kentucky and his J.D. from the Duke Law School.

Maria T. Wensus, LSW, is the Pharmacotherapy Program Coordinator for the Aldie Counseling Center in Doylestown, Pennsylvania. In an earlier position as Lead Therapist with Aldie, Ms. Wensus assisted with the start-up and integration of the Pharmacotherapy Program into a previously drug-free setting. Her 11-year career in the field also includes experience as a clinical supervisor, care manager, and therapist in crisis intervention, student assistance, and alternative education settings. Ms. Wensus received a B.S. in Human Development and Family Studies from The Pennsylvania State University and her M.S.W. from Temple University.

The Bucks County Drug and Alcohol Commission, Inc.
and
The Center for Substance Abuse Treatment (CSAT)

present

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General Information

The Bucks County Drug & Alcohol Commission, Inc. (BCDAC, Inc.) was created in 1973 in response to concerns about the impact of alcohol and other drug abuse and dependency on our population. Initially established as a department of county government, BCDAC, Inc. moved to a private not-for-profit status in July of 1987.

Although a private agency, BCDAC, Inc. maintains a close working relationship with county government and functions as part of the Bucks County Division of Human Services (DHS) and the Bucks County Behavioral Health System (BCBHS). The county continues to provide matching funds for programs and remains the contractee with the Pennsylvania Departments of Health (Bureau of Drug and Alcohol Programs) and Welfare (Office of Mental Health and Substance Abuse Services) and with other state and federal agencies that may award funds to us.

MISSION STATEMENT

The Bucks County Drug and Alcohol Commission, Inc. serves as the Single County Authority (SCA) responsible for facilitating the provision of a comprehensive and balanced system of quality substance abuse prevention, intervention and treatment services for county residents. The Commission seeks to eliminate addiction, alleviate its effects and ultimately eliminate the abuse and misuse of alcohol, tobacco and other drugs in the county.

The Bucks County Drug and Alcohol Commission, Inc. also serves to foster planning and service delivery partnerships on local and regional levels where such collaborations result in efficient and effective utilization of health care and human services resources.

The Commission will effectively empower the development and maximization of Bucks County resources - human, physical and financial - in keeping with its mission and toward the achievement of its goals.

GOALS OF THE COMMISSION

- BCDAC, Inc. will develop and implement effective solutions to alcohol, tobacco, and other drug related prevention, intervention and treatment concerns and problems through innovative problem solving, planning, advocacy, administration, education and funding strategies at the local and regional level.

- All Bucks County residents, including those with special needs, will have convenient access to a full continuum of quality prevention, intervention and treatment services. These services will be age and culturally appropriate.

- There will be a decrease in the number of Bucks County residents, especially school age children, using alcohol, tobacco and other drugs leading to a reduction in alcohol, tobacco, and other drug related violence and a decline in involvement with the legal and medical systems.

The Bucks County Drug and Alcohol Commission, Inc. is acknowledged as the lead agency for alcohol, tobacco and other drug (ATOD) abuse related prevention, intervention and treatment services for Bucks County residents. As such, we perform a variety of functions designed to ensure that individuals and family members who are affected by substance abuse and dependency have quality services available to help them.

THE BUCKS COUNTY DRUG & ALCOHOL COMMISSION, INC. PROVIDES FOR THE FOLLOWING:

DEVELOPMENT OF A COUNTY PLAN for prevention, intervention and treatment services occurs every three to five years with annual updates. Public hearings are advertised and we welcome input from individuals and groups at anytime during the year. We utilize federal, state and local funds to finance this plan and we award funds to various agencies to provide services. The ***Bucks County Drug and Alcohol Commission, Inc. 2002-2003 State Plan Update*** is the plan document under which we are currently operating. Copies of this document and the forthcoming 2003-2004 State Plan Update are available at all public libraries, the Bucks County Office of Public Information and BCDAC, Inc. offices. Your input into our planning process is very important to us, and your suggestions, complaints and grievances will be welcomed at any time during the year.

During this coming year we will begin planning for a corporate strategic plan for 2004-2007. We will notify county residents about opportunities for involvement in this process which will include workshops, focus groups and surveys. We intend to work collaboratively with the Communities That Care and America's Promise – initiatives in this process.

CLIENT SERVICES including pre-screens and assessments, care management, intervention and treatment services, intensive case management and mobile engagement services. These services are available, as funding allows, to those without insurance coverage and/or who do not otherwise have access to subsidized care through another payment system, i.e. Medicaid, Medicare, Veteran's Services Center, etc.

- **Pre-Screen and Assessment Services** for children, adolescents and adults are available through a subcontracting arrangement with licensed community agencies throughout the

county. Assessors are required to complete a number of trainings on standardized instruments for assessment and placement recommendations.

- **Care Management Services** are provided by our staff to ensure that clients seeking treatment receive a quality assessment and are referred to the appropriate level of care. This service includes continuing care reviews and other utilization management and quality assurance functions designed to facilitate the movement of clients from one level of care to another.

- **Intervention Services** are those designed to assist an individual and/or family member to recognize their need for help to address their use, abuse or dependency to alcohol, tobacco and/or other drugs. We fund both school and community-based intervention alternatives, with a special emphasis on early intervention programs for school age children and adolescents. We also finance specialized intervention services for those involved within the criminal justice system.

- **Treatment Services** financed by our office include outpatient, intensive outpatient, methadone maintenance, partial hospitalization and residential alternatives. Specialty services for adolescents, women, seniors, intravenous drug users, incarcerated individuals, Spanish-speaking, hard-of-hearing and deaf clients are just a few of the options available to county residents. Assessment and counseling are also provided at homeless shelters, transitional living and senior housing sites. Client liability is determined according to a sliding fee scale. BCDAC, Inc. can subsidize a portion of the treatment costs for many residents who do not have insurance or another source of funding, and who meet our funding criteria. Clients on Medical Assistance (Medicaid) can access care through the county's HealthChoices behavioral health managed care program.

- **Intensive Case Management Services** are provided by our staff through a strength-based model to ensure that clients receive the support or ancillary services they need to recover from dependency and to achieve self sufficiency. A specialized intensive case management program is operated in the Bucks County Correctional Facilities for female offenders. We additionally provide these services to priority clients whose treatment in financed through the Medicaid behavioral health managed care program.

- **Mobile Engagement Services** are made available through select agencies to assist in engaging clients in treatment. This includes special projects for adolescents, pregnant women and for individuals with a history of multiple relapses.

QUALITY OF CARE REVIEWS are accomplished through an extensive quality assurance and licensing process with all subcontractors. A continuous quality improvement process (CQI), that includes consumer satisfaction surveys and follow-up studies, is also in place for all levels of care. The BCDAC, Inc. utilizes the Client Advisory Board (CAB), made up of current and former intensive case management clients, to assist in a review of our client related policies and procedures and to provide us with important feedback on intervention and treatment services. Additionally we work with PRO-ACT, a locally based advocacy program in the development and implementation of consumer surveys.

GRIEVANCE AND APPEAL PROCEDURES and a **CLIENT BILL OF RIGHTS** are in place to ensure that clients and their families have an opportunity for a fair hearing should problems arise during their treatment experience.

COMMUNITY EDUCATION AND OUTREACH SERVICES are provided through various subcontractors and include special projects in predominantly African American and Latino neighborhoods, and for populations designated as high risk for substance abuse and dependency. Pamphlets, films and videos, speakers and reference materials are available through several subcontractor sites and a national computer network for specialized information is available.

PREVENTION & TRAINING SERVICES are provided through various subcontractors. We encourage proactive efforts to promote healthy lifestyles and prevent inappropriate use and abuse of alcohol, tobacco and other drugs. We strive to empower communities to become involved in quality and long-term community based prevention efforts, including violence prevention activities, and we provide technical assistance to this end. We view initiatives such as Communities That Care (CTC) and America's Promise as the best ways for us to achieve the county's goals for drug-free communities and healthy life-styles.

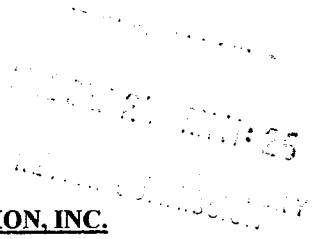
BUCKS COUNTY DRUG & ALCOHOL COMMISSION, INC.
6000 Lewis Drive, Suite 102 A, Warminster PA 18974
(215) 773-9313, Fax: (215) 956-9939
email: bcdac@co.bucks.pa.us

BUCKS COUNTY DRUG & ALCOHOL COMMISSION, INC.

DRUG AND ALCOHOL EXECUTIVE COMMISSION

Robert E. Kelsey, Chairperson 424 Long Avenue Langhorne, PA 19047	(h) 215-752-2308 (w) 215-442-0209 (f) 215-442-0693 kelsey50@bellatlantic.net rekelsey@co.bucks.pa.us	Criminal Justice Category Appointed 8/6/97 2nd term expires 7/30/03
Paul Regul, Vice-Chair 641 Schwenkmill Road Perkasie, PA 18944	(h) 215-257-8189 (w) 215-661-2585 (f) 215–616-6317 pregul@comcast.net Pager 888-443-7952	Community Category Appointed 9/8/00 1st term expires 9/6/03
Darlene Stedman, Secretary Stedman's Inc. Woodbine Plaza, 2636 Bristol Pike Bensalem, PA 19020	(w) 215-639-8770 (f) 215-639-8771 info@stedmansinc.com dstedman@stedmansinc.com	Business Category Appointed 2/18/98 2nd term expires 2/18/04
Greg Lentz, Treasurer ZA Consulting 101 West Avenue, Suite 300 Jenkintown, PA 19046	phone & fax cell phone	(h) 215-396-7915 (w) 215-517-4931 (f) 215-572-4970 215-808-0477 glentz@zaconsulting.com gclentz@earthlink.net	Business Category Appointed 7/22/98 2nd term expires 7/22/04
Betty Bell 80 Carousel Circle New Britain, PA 18901	(h) 215-345-5474 (w) 215-230-4500 (f) 215-230-8132 bbell@firstservicebankonline.com	Business Category Appointed 8/06/97 2nd term expires 7/30/03
Michael Burns, Esquire One Oxford Valley, Suite 301 Langhorne, PA 19047	(h) 215-750-0287 (w) 215-750-7271 (f) 215-750-1933 mjburnsesq@psualum.com	Business Category Appointed 4/3/02 1st term expires 7/30/04
Chris Demetriou 3625 Bryon Rd. Doylestown, PA 18901	(h) 215-794-4997 cmdemetriou@earthlink.net	Student Category Appointed 6/6/01 1st term expires 6/6/04
Michael T. Fay 2336 Magnolia Way Jamison, PA 18929	(h) 215-491-9372 tfaymike8@yahoo.com	Student Category Appointed 6/6/01 1st term expires 6/6/04

Gloria Hall 50 Bittersweet Dr. Doylestown, PA 18901	(h) 215-230-9092 glodouggy@aol.com	Community Category Appointed 6/6/01 1st term expires 6/6/04
Bryan Hutchinson 251 South Olds Blvd. #D-70 Fairless Hills, PA 19030	(h) 215-269-9592	Community Category Appointed 1/16/01 1st term expires 1/3/04
Mary Ann Mason 2536 Madara Road Bensalem, PA 19020-1317	(h) 215-638-9319 (w) 215-504-3942 (f) 215-579-4514 MARNSYLMSN@aol.com	Community Category Appointed 1/16/01 1st term expires 1/03/04
Gladys Mendieta 1731 Fulling Mill Road Langhorne, PA 19047	(h) 215-860-0269 (w) 215-781-9510 gladys@latinavoice.com	Business Category Appointed 12/7/00 1st term expires 12/06/03
Mark Morgan 57 Main Street, Apt 1 Fallsington, PA 19054	(h) 215-237-9311 (w) 215-442-1599 (f) 215-442-9710 nagrom@covad.net	Community Category Appointed 1/16/01 1st term expires 1/3/04
Gordian V. Ehrlacher Public Health Administrator Health Department Neshaminy Manor Center Route 611 & Almshouse Road Doylestown, PA 18901	(w) 215-345-3322 (f) 215-345-3833 gvehrlacher@co.bucks.pa.us	Represents Bucks County Health Dept. Ex officio non-voting member
Beverly Haberle, Executive Director BCCADD, Inc. Bailiwick Office Campus, Unit #12 252 West Swamp Road Doylestown, PA 18901-2444	(w) 215-345-6644 (f) 215-348-3377 bhaberle@bccadd.org	Represents Service Providers Advisory Task Force Ex officio non-voting member
Margaret E. Hanna 17 Naylor Court Quakertown, PA 18951	(w) 215-773-9313 (h) 215-536-0411 215-896-4045 cell mehanna@nni.com (home) mehanna@co.bucks.pa.us	fax 215-956-9939 fax 215-804-0789



BUCKS COUNTY DRUG & ALCOHOL COMMISSION, INC.

600 Louis Drive, Suite 102-A
Warminster, PA 18974
215-773-9313 (t)
215-956-9939 (f)
BCDAC@co.bucks.pa.us

General Information

The Bucks County Drug & Alcohol Commission, Inc. (BCDAC, Inc.) was created in 1973 in response to concerns about the impact of alcohol and other drug abuse and dependency on our population. Initially established as a department of county government, BCDAC, Inc. moved to a private not-for-profit status in July of 1987.

BCDAC, Inc. serves a the Single County Authority (SCA) responsible for facilitating the provision of a comprehensive and balanced system of quality substance abuse prevention, intervention and treatment services for residents. The Commission seeks to eliminate addiction, alleviate its effects and ultimately eliminate the abuse and misuse of alcohol, tobacco and other drugs in Bucks County.

WHERE TO GO FOR AN ASSESSMENT:

In order for a Bucks County resident to receive funding for treatment, specific criteria must be met. An assessment may be scheduled at any of the following licensed treatment providers:

PRIMARY ASSESSMENT SITES:

- Aldie Counseling Center (215) 345-8530
  228 N. Main Street, Doylestown, PA 18901
- Livengrin Foundation (215) 781-2048
  1270New Rogers Road. Bristol, PA 19007
- Penn Foundation (215) 257-9999
  807 Lawn Avenue, Sellersville, PA 18960

GRIEVANCE AND APPEAL PROCESS:

BCDAC, Inc. and all providers offer a Grievance and Appeals Process. A complaint may be made to the Supervisor of Care Management, at:
Bucks County Drug & Alcohol Commission, Inc.
600 Louis Drive
Suite 102-A
Warminster, PA 18974
(215) 956-9934 (t)
(215) 956-9937 (f)

We will work to ensure the resolution of this complaint or grievance, and will assist in filing a grievance, as necessary.

BCDAC, Inc.

Case Management Services Unit Staff

Margie Rivera
Intensive Case Management Supervisor

Sybil Henderson
Lead Case Manager

Dana Roberson
Intensive Case Management Specialist

Maria Duprey
PCCD Case Management Specialist

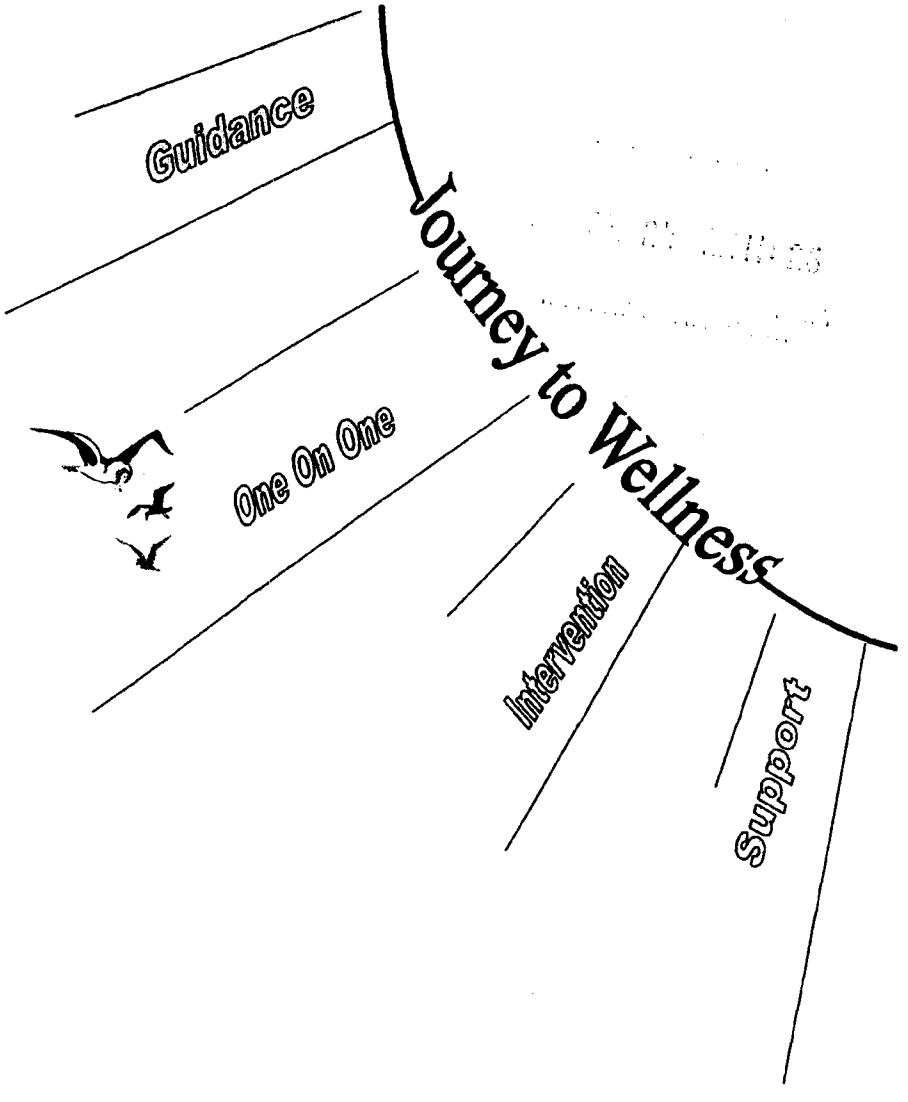
Andrea Guerra
Administrative Assistant

Jill Voit
PCCD Case Management Assistant

This brochure was developed, in part, by the Client Advisory Board of the Bucks County Drug & Alcohol Commission, Inc. Case Management Services Unit.

Services are provided and employment/applicant for employment is made without regard to age, race, color, religion, sex, life style, affectional or sexual orientation, ancestry, national origin or disability except where there is a bonafide occupational qualification.

"This project made possible by an agreement with the Pennsylvania Department of Health, Bureau of Drug and Alcohol Programs. The Bureau of Drug and Alcohol Programs specifically disclaims responsibility for any analysis, interpretations, or conclusions herein."



Case Management Services Unit
Bucks County Drug & Alcohol Commission, Inc.
1200 New Rodgers Road
Suite B-2, Box 852
Bristol, PA 19007
(215) 788-8172

G. R. A. S. P. Hold of Life...

- **G**UIDANCE

  Lending a hand, step by step, to help you make choices

- **R**EFERRAL

  Providing a sense of direction on where to turn

- **A**DVOCACY

  Helping you to stand up for your self

- **S**UPPORT

  Motivating and encouraging you

- **P**ERSONALIZED

  Providing one-on-one assistance in getting services you may need

Break Free From Addiction!

Our goals are to help you:

- Move into recovery and independence
- Recognize and build upon your strengths

The Case Management Services Unit is here to help you.

Give us a call at
(215) 788-8172

Rays of Hope

Required Documentation for Approved Pennsylvania Certification Board (PCB) 12 credits for attendance at this conference

1. Complete the information form attached and submit at the CEU Registration table in the lobby at the beginning of the conference.

2. Sign the attendance sheet, at the CEU Registration table <u>first thing each morning and at the end of each day</u>.

3. Complete the Conference Evaluation Form in your packet

4. Exchange the Conference Evaluation Form for your certificate of attendance at the end of the conference from the CEU Registration table.

ENJOY THE CONFERENCE!

Bucks County Drug & Alcohol Commission, Inc.
Training Registration Form

Please complete all sections, printing clearly and return to the CEU Registration table. Thank you.

Name: _____ __ _____
Last MI First

Agency Name: _____

Agency Address: _____

_____

_____

Telephone: _____ E-Mail: _____

Fax: _____

Current Position Title: _____

Title of Training: Pharmacotherapy & Narcotic Dependence: Best and Promising Practices

Dates of Training: September 9-10, 2002

Approved PCB Credit Hours: 12

Your Signature & Date: _____ _____
Signature Date

Required Documentation for Approved CEUs for Licensed Social Workers

1. Complete the information (on the flip side of this paper) and submit at the CEU Registration table in the lobby at the beginning of the conference.

2. Complete the *Conference Evaluation Form* in your packet.

3. Sign the attached *Statement of Attendance Form.*

4. Bring both the *Statement of Attendance* Form and the *Conference Evaluation Form* to the CEU Registration table at the end of the cofnerence. You must also pay a $15 certificate fee, check payable to BCDAC, Inc. You will receive a formal certificate in the mail from the institution issuing the credits.

ENJOY THE CONFERENCE!

Bucks County Drug & Alcohol Commission, Inc.
Training Registration Form

Please complete all sections, printing clearly and return to the CEU Registration table. Thank you.

Name: _____ __ _____
Last MI First

Agency Name: _____

Agency Address: _____

_____

_____

Telephone: _____ E-Mail: _____

Fax: _____

Current Position Title: _____

Title of Training: Pharmacotherapy & Narcotic Dependence: Best and Promising Practices

Dates of Training: September 9-10, 2002

Approved CEUs for PA Licensed Social Workers: 10.5

Your Signature & Date: _____ _____
Signature Date

Statement of Attendance
To document CEUs

Event: Pharmacotherapy and Narcotic Dependence: Best and *Promising Practices*

Date: September 9-10, 2002

Approved CEUs: 10.5 for PA State Board of Social Work Examiners through a formal co-sponsorship agreement with the Bryn Mawr School of Social Work and Social Research

My signature below attests that I attend all scheduled events of the September 9-10, 2002 conference listed above, fulfilling the requirement for the 10.5 CEUs.

Printed Name: _____

Signature: _____ Date: _____

PHARMACOTHERAPY AND NARCOTIC DEPENCENCE: BEST AND PROMISING PRACTICES

Conference Evaluation Form

September 9-10, 2002

I. Overall Conference Evaluation

		TOO MUCH	BALANCED	NOT ENOUGH
A.	SUBJECT CONTENT			
	1. Theoretical	☐	☐	☐
	2. Practical	☐	☐	☐

		TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
B.	SUBJECT LEVEL	☐	☐	☐

		EXCELLENT	GOOD	FAIR	POOR
C.	FACILITY	☐	☐	☐	☐

D. PLEASE RECORD YOUR OVERALL REACTIONS TO THIS CONFERENCER BY PLACING AN "X" IN THE APPROPRIATE BOX OF THE SCALE

Excellent								Good					Fair						Poor
20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

E. YOUR SUGGESTIONS FOR IMPROVEMENT WOULD BE APPRECIATED

_____

_____

_____

F. OTHER COMMENTS: INCLUDING OTHER TRAININGS YOU WOULD LIKE TO SEE.

_____

_____

_____

(Please turn to other side)

PLEASE RATE EACH SPEAKER

II. Dr. Trusandra Taylor

A. SUBJECT CONTENT	TOO MUCH	BALANCED	NOT ENOUGH
1. Theoretical	☐	☐	☐
2. Practical	☐	☐	☐

B. SUBJECT LEVEL	TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
	☐	☐	☐

C. PRESENTATION	EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
1. Ability to Communicate	☐	☐	☐
2. Emphasis of key Points	☐	☐	☐
3. Visual Aids (if used)	☐	☐	☐
4. Handout Material	☐	☐	☐

III. Mark Parrino. M.P.A.

A. SUBJECT CONTENT	TOO MUCH	BALANCED	NOT ENOUGH
1. Theoretical	☐	☐	☐
2. Practical	☐	☐	☐

B. SUBJECT LEVEL	TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
	☐	☐	☐

C. PRESENTATION	EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
1. Ability to Communicate	☐	☐	☐
2. Emphasis of key Points	☐	☐	☐
3. Visual Aids (if used)	☐	☐	☐
4. Handout Material	☐	☐	☐

PLEASE RATE EACH SPEAKER

IV. Treating the Pharmacotherapy in a "Drug Free" Panel

A. SUBJECT CONTENT	TOO MUCH	BALANCED	NOT ENOUGH
1. Theoretical	☐	☐	☐
2. Practical	☐	☐	☐

B. SUBJECT LEVEL	TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
	☐	☐	☐

C. PRESENTATION	EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
1. Ability to Communicate	☐	☐	☐
2. Emphasis of key Points	☐	☐	☐
3. Visual Aids (if used)	☐	☐	☐
4. Handout Material	☐	☐	☐

V. Criminal Justice Panel

A. SUBJECT CONTENT	TOO MUCH	BALANCED	NOT ENOUGH
1. Theoretical	☐	☐	☐
2. Practical	☐	☐	☐

B. SUBJECT LEVEL	TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
	☐	☐	☐

C. PRESENTATION	EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
1. Ability to Communicate	☐	☐	☐
2. Emphasis of key Points	☐	☐	☐
3. Visual Aids (if used)	☐	☐	☐
4. Handout Material	☐	☐	☐

(Please turn to other side)

PLEASE RATE EACH SPEAKER

VI. Harris Gubernick

A.	SUBJECT CONTENT		TOO MUCH	BALANCED	NOT ENOUGH
	1.	Theoretical	☐	☐	☐
	2.	Practical	☐	☐	☐
B.	SUBJECT LEVEL		TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
			☐	☐	☐
C.	PRESENTATION		EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
	1.	Ability to Communicate	☐	☐	☐
	2.	Emphasis of key Points	☐	☐	☐
	3.	Visual Aids (if used)	☐	☐	☐
	4.	Handout Material	☐	☐	☐

VII. Judge Henry Weber

A.	SUBJECT CONTENT		TOO MUCH	BALANCED	NOT ENOUGH
	1.	Theoretical	☐	☐	☐
	2.	Practical	☐	☐	☐
B.	SUBJECT LEVEL		TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
			☐	☐	☐
C.	PRESENTATION		EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
	1.	Ability to Communicate	☐	☐	☐
	2.	Emphasis of key Points	☐	☐	☐
	3.	Visual Aids (if used)	☐	☐	☐
	4.	Handout Material	☐	☐	☐

PLEASE RATE EACH SPEAKER

VIII. Bert Pepper

		TOO MUCH	BALANCED	NOT ENOUGH
A.	SUBJECT CONTENT			
1.	Theoretical	☐	☐	☐
2.	Practical	☐	☐	☐

		TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
B.	SUBJECT LEVEL	☐	☐	☐

		EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
C.	PRESENTATION			
1.	Ability to Communicate	☐	☐	☐
2.	Emphasis of key Points	☐	☐	☐
3.	Visual Aids (if used)	☐	☐	☐
4.	Handout Material	☐	☐	☐

IX. Creating the Best Climate for Recovery Panel

		TOO MUCH	BALANCED	NOT ENOUGH
A.	SUBJECT CONTENT			
1.	Theoretical	☐	☐	☐
2.	Practical	☐	☐	☐

		TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
B.	SUBJECT LEVEL	☐	☐	☐

		EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
C.	PRESENTATION			
1.	Ability to Communicate	☐	☐	☐
2.	Emphasis of key Points	☐	☐	☐
3.	Visual Aids (if used)	☐	☐	☐
4.	Handout Material	☐	☐	☐

(Please turn to other side)

PLEASE RATE EACH SPEAKER

X Jeff Kegley

A.	SUBJECT CONTENT		TOO MUCH	BALANCED	NOT ENOUGH
	1.	Theoretical	☐	☐	☐
	2.	Practical	☐	☐	☐
B.	SUBJECT LEVEL		TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
			☐	☐	☐
C.	PRESENTATION		EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
	1.	Ability to Communicate	☐	☐	☐
	2.	Emphasis of key Points	☐	☐	☐
	3.	Visual Aids (if used)	☐	☐	☐
	4.	Handout Material	☐	☐	☐

XI. Peter DeMaria

A.	SUBJECT CONTENT		TOO MUCH	BALANCED	NOT ENOUGH
	1.	Theoretical	☐	☐	☐
	2.	Practical	☐	☐	☐
B.	SUBJECT LEVEL		TOO ELEMENTARY	JUST RIGHT	TOO ADVANCED
			☐	☐	☐
C.	PRESENTATION		EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
	1.	Ability to Communicate	☐	☐	☐
	2.	Emphasis of key Points	☐	☐	☐
	3.	Visual Aids (if used)	☐	☐	☐
	4.	Handout Material	☐	☐	☐

Did "Clean Up Amendments" make it in to the new Act?

Legislative service agency – didn't make it in.

#8 – p. 11 of bill top of page - require del. To Commission – Will we get copy of transmittal sheet so we know they were delivered to committees?

#13, 14, 15 don't apply

NEW STUFF

p. 5, line 11 – "within 5 business days" – only place in act that uses business days – all others in the act are calendar days. Why?

p. 5, line 23 –Committee may deliver comments to agency AND commission. Is this consistent with p. 8, line 5, which used the word OR?

p. 5, line 25 – questioning change from "shall" to "may" – lines 24 – 29 – Is it necessary or should it include all the criteria?

p. 6, line 24 (f) should be (e), p.7, line18 (g) should be (f).

p. 7, line 18 - Section 5(f) - Three concerns: 1) we comment before committees are formed, no chance to review their comments; 2) if we comment before the committees are formed and the agency doesn't resubmit after they're formed, it would be deemed withdrawn and we would have commented on a reg that was deemed withdrawn before the committees ever saw it; 3) Line 4 changes "shall" to "may" and states that the agency may submit the proposed regulation and required material to the committees no later than the second Monday after committees are designated. Line 14 – 17 states that if the agency fails to deliver the proposed regulation and all materials "**required**" under this section in the time prescribed, the agency is deemed to have withdrawn the proposed regulation. If the Act uses the word "may," what is "required" and what time is prescribed?

p. 8, lines 8-15, the first two sentences of Section 5.1(a) describe actions that an agency needs to take during the proposed stage of a regulation. Should these two sentences be moved to Section 5?

p. 10, line 15 and 18 – LRB changed the language and it doesn't work. The word "have" is missing and should be placed before the word "until" on line 15, and the word "to" is missing and should be placed before the word "approve" on line 18.

p. 10, lines 15 – 18, Subsection (e) "no less than 30 days after receipt" – no cap – does this allow IRRC potentially to sit on a reg? See p. 2, lines 10-11, when does IRRC review period expire?

p. 11 – Why were lines 9 – 14 removed?

p. 12, line 26 thru 28 (regarding tolling) – Three concerns: 1)same issue relating to the word "may"; 2) style changes by LRB don't make sense; 3) is 15 days too much (Bob's concern)

p. 13, line 3 – Should "respective time periods " be changed to singular? –and take out respective?

p. 15, line 11 (regarding blackout period) – Several concerns: 1) Could the "unless comments are submitted at the request of " leave us open to criticism of favoritism? 2) Could it be for clarification of previous comments? 3)Will this be problematic on controversial regs? 4)What does "at the request of the Commission" mean? 5)Is this any call from an analyst, will we need to document, etc. This is an administrative/procedural question.

p. 15, line 18 – Comments during blackout must be sent "upon receipt." On faxes, if it comes in at 8 p.m. – is that the receipt time and are we held to sent it to the committee and agency "upon receipt."? This could be administrative problem.

p. 15, line 21 – (j.1) – inconsistent language – should refer to the commission and the agency throughout. In Mary's amendment language -----

p. 16 –11, 12, 13 (regarding new 14 days for committee review) – Is the resubmittal to the Commission informational?

p. 16, lines 23 thru 29 (regarding committee review during sine die) – Why not simplify and allow 14 days, for committee review?

p. 17, line 7 – typo – section 6(e) should be section 6(d).

p. 18, line 8 – contains the words "final-form or final-omitted" and is not consistent with lines 21-22 on page 17. Recommend one of two fixes: 1) inserting "proposed," before "final-form" and replacing "or" with "," after "final-form" and adding "or existing" after "final-omitted"; or 2) or deleting "final-form or final-omitted" from this criterion.

p. 21, line 2 – Subsection (d) should be subsection (c).

p.21, line 24 (regarding procedures for review of a disapproved regulation) – The requirement that an agency has 7 days to notify Governor, committees and commission of it decision is being deleted. Does this make sense? (Bob's concern)

p. 24, line 17 - the LRB left out the word "have" between "may" and "until" - its stylistic but I think Mary's version is more understandable.

act review9/26/2002

p. 25 lines 24 and 25 - Mary's draft had bracketed out "or of the commission's order pursuant to section 6(c)" - but the LRB left it in - it doesn't read right with it in and needs to be fixed.

MacNett Amendment on approval or disapproval by committees

Subsection j.1 indicates that the committee may notify the agency and IRRC that it intends to review the regulation. However, there is no language indicating that a committee may notify the agency and IRRC that it voted to approve or disapprove the regulation. How will we know if the committee acts?

CONFERENCE CHALLENGE II
CONSUMER PERSPECTIVE

ADDITIONAL SERVICES

BC-CST offers educational & informative workshops dealing with:

- Partnership approach to consumer satisfaction
- Successful employment and support of consumers & family members
- How to advocate for yourself
- Dual Diagnosis-mental illness/substance abuse
- Empowerment

Should you have any questions, comments and/or concerns about services, the BC-CST, Inc., or if you wish to receive our newsletter please write or call.

YOUR VOICE MAKES A DIFFERENCE!

****

The BC-CST, INC. is a nonprofit organization that operates with funds provided through the Bucks County Department of Mental Health/Mental Retardation. Additional funds may come from private donations, grants and managed care companies.

MISSION STATEMENT

THE MISSION OF
THE BC-CST, INC.
IS THE ASSESSMENT OF
CONSUMER SATISFACTION
BY CONSUMERS
AND FAMILY MEMBERS
AND
THE MAKING OF RECOMMENDATIONS
TO IMPROVE
BEHAVIORAL HEALTH SERVICES
AND SUPPORTS IN THE
MENTAL RETARDATION SYSTEM.

****

OUTCOMES

CHANGES
ARE MADE IN
SERVICES AND SUPPORTS
BECAUSE
CONSUMERS VOICE
THEIR SATISFACTION/
DISSATISFACTION
AND THEIR
RECOMMENDATIONS FOR
CHANGES/IMPROVEMENTS

BC-CST, INC.

Bucks County –
Creating Satisfaction Together

****

BC-CST, Inc.
600 Louis Drive, Suite. 106
Warminster, PA 18974
(215) 442-1599
or
1-800-734-5665
FAX (215) 442-9710

E-MAIL ADDRESS:
bccst.bhs.consumervoice@erols.com

****

Consumers & Family Members making recommendations to improve Services and Supports.

CONSUMER SATISFACTION

We believe consumer satisfaction is achieved through:

Participation in well-rounded services, supports and activities of the consumer's choice as needed or wanted, with the opportunity to voice their opinions in an environment of empowerment, respect and dignity so that they are able to move on in the process of recovery and obtain an improved quality of life.

****

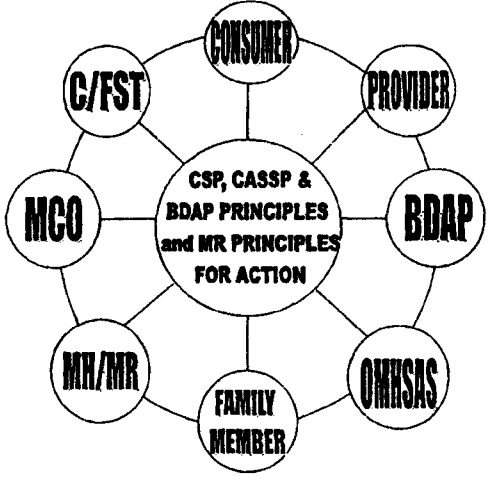
WHAT WE DO

The core of our mission and activities stem from CSP, CASSP & BDAP Principles and MR Principles For Action. Through these principles, BC-CST, INC. is able to offer opportunities through which consumers and family members talk about issues that are important to them as well as identify & report their level of satisfaction with their services and supports.

HOW WE DO IT

The BC-CST is here to serve the community. To accomplish our goal we gather information by way of one-on-one interviews, focus groups, questionnaires, phone calls and through the mail. This information is shared with consumers, family members, service providers and the Bucks County Department of Mental Health/Mental Retardation in order to improve the quality of life for people and the quality of services and supports.

BC-CST uses a partnership approach. We believe in "Creating Satisfaction Together", which means that all of the stakeholders have a responsibility in working toward consumer satisfaction and improving services and supports.



BC-CST CORE VALUES

Two main values govern the BC-CST activities and processes:

1. People must be treated with dignity and respect.

2. A partnership approach (Consumers, Families, Providers, MH/MR and other County Departments, MCOs, & BC-CST) is necessary in achieving the ABC's of satisfaction.

A. ***Accepting*** "people first" & ***Assessing*** satisfaction.

B. ***Bringing*** togetherness & ***Building*** relationships.

C. ***Creating*** success & ***Changing*** the system.

EVERYONE'S INPUT IS IMPORTANT * SO LET'S CREATE SATISFACTION TOGETHER!

ADDICTIONOLOGY AND OPIOID DEPENDENCY

Pharmacotherapy and Narcotic Dependency: Best and Promising Practices

September 9-10, 2002

Bucks County Drug and Alcohol Commission, Inc.

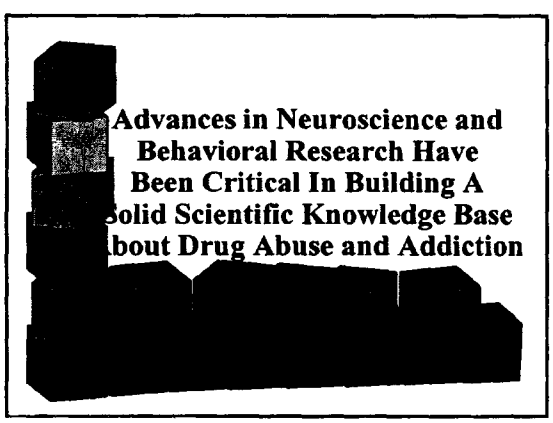
Addiction Medicine and Opioid Addiction

Trusandra Taylor, MD

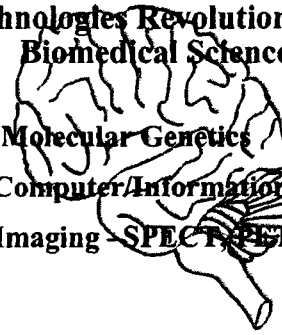
Course Objectives

- **Neurobiology / Psychopharmacology**
- **Epidemiology / Demographics**
- **Multiple Substance Abuse**
- **Abstinence and Recovery**
- **Patient Profiles of Recovery**
- **Comprehensive MAT**
- **Future Directions**

Neurobiology /
Psychopharmacology



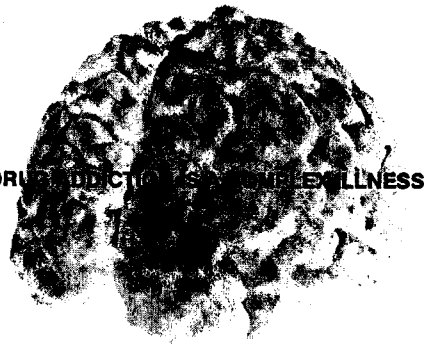
Technologies Revolutionizing Biomedical Science



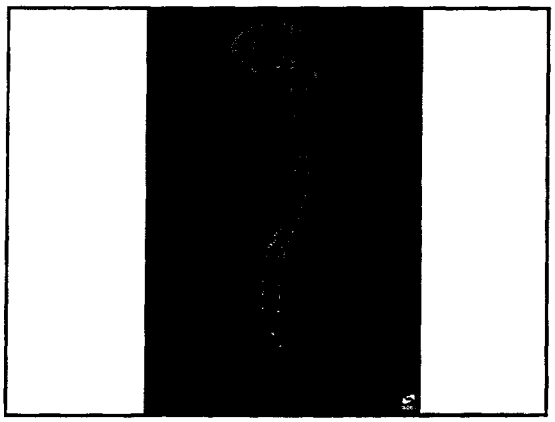
- Molecular Genetics
- Computer/Information Science
- Imaging - SPECT, PET, MRI

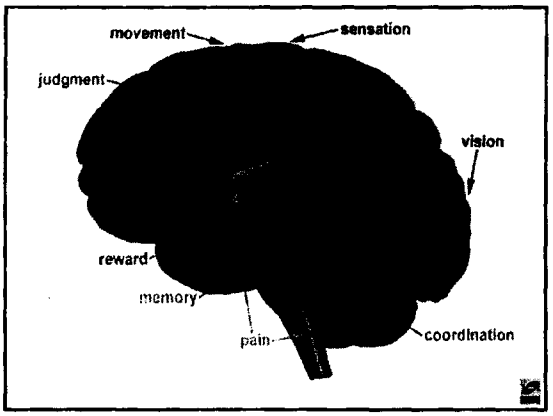
"Opioid Addiction is a brain disease"

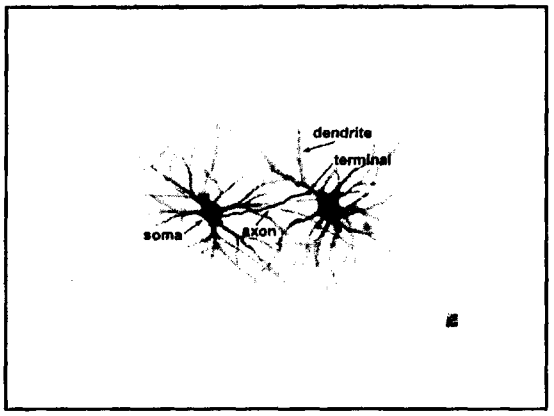
"Addiction is more than a just a brain disease."

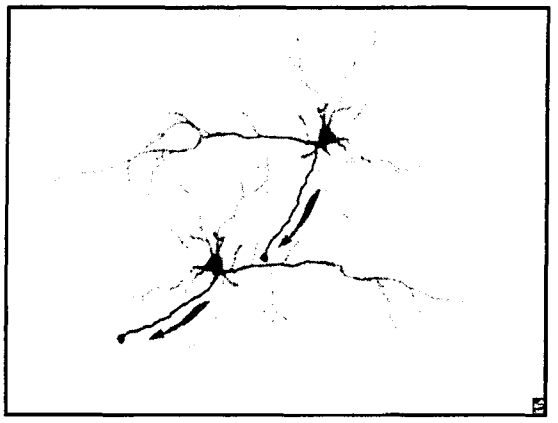


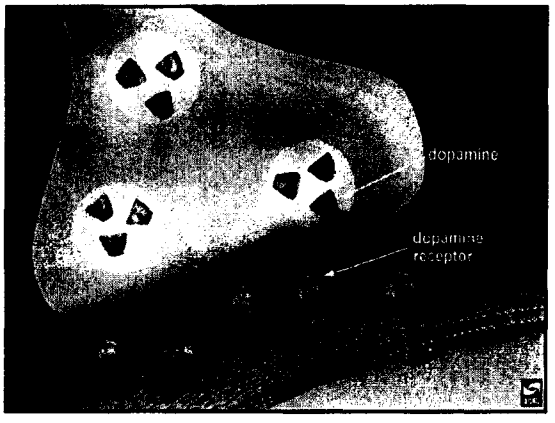
Introduction to the brain

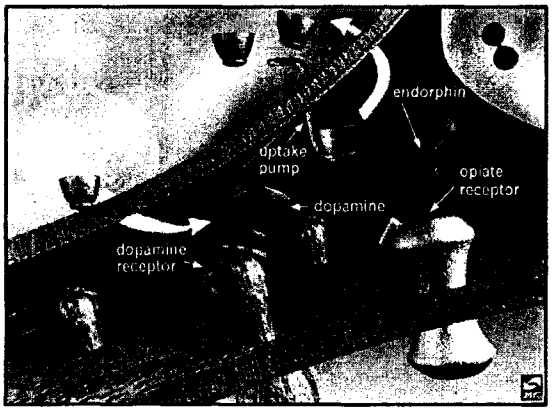



movement
sensation
judgment
vision
reward
memory
pain
coordination


dendrite
terminal
soma
axon



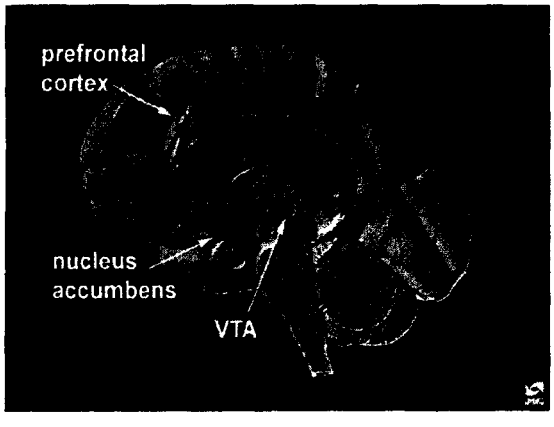

dopamine
dopamine
receptor

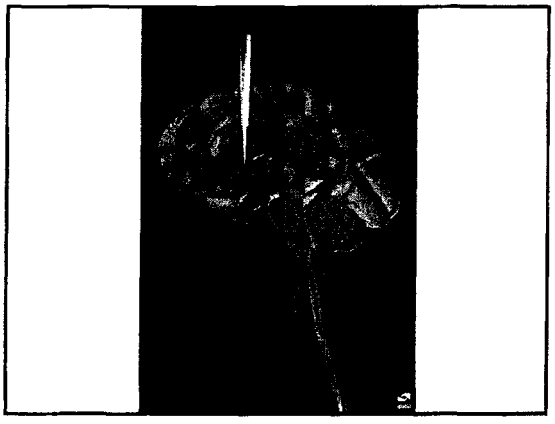

endorphin
uptake
pump
opiate
receptor
dopamine
dopamine
receptor

The Reward Pathway and Addiction

Natural Rewards

Food
Water
Sex
Nurturing



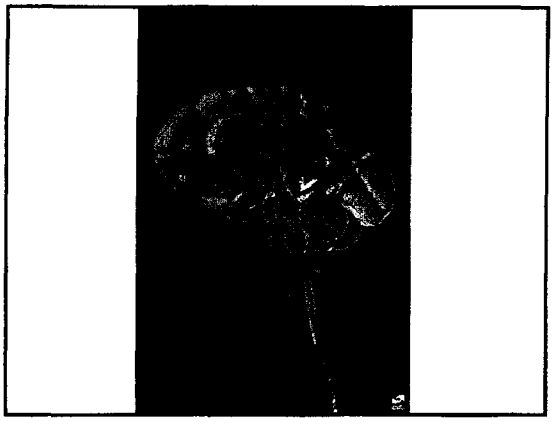


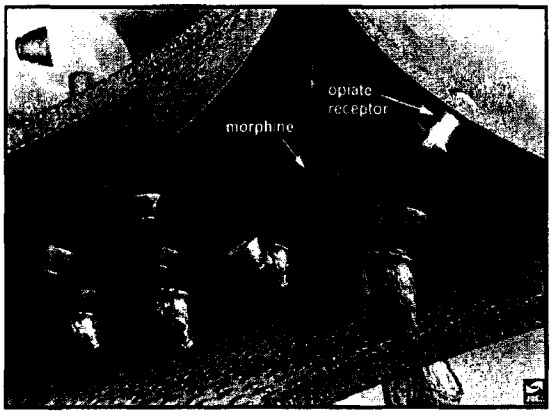
Addiction

A state in which an organism engages in a compulsive behavior

- behavior is reinforcing (rewarding or pleasurable)
- loss of control in limiting intake

The Action of Heroin (Morphine)

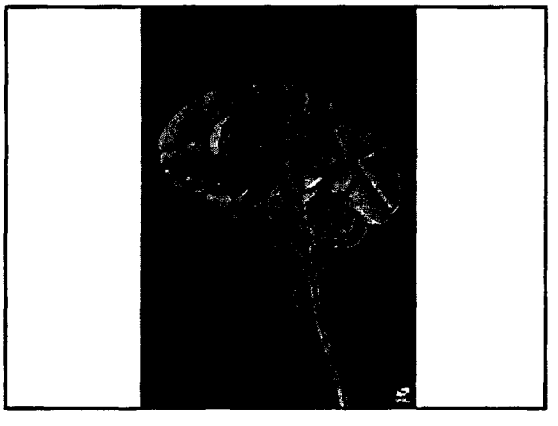



opiate
receptor
morphine

Tolerance

A state in which an organism no longer responds to a drug

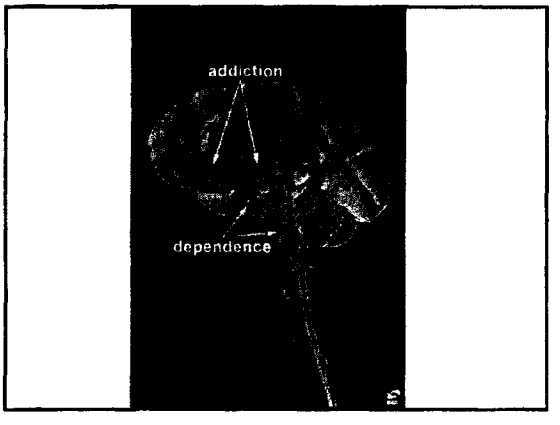
- a higher dose is required to achieve the same effect



Dependence

A state in which an organism functions normally only in the presence of a drug

- manifested as a physical disturbance when the drug is removed (withdrawal)



Basic Opioid Pharmacology

Opioid Receptors

- Mu
- Kappa
- Delta

Functional Opioid Pharmacololgy

- Agonists
- Antagonists
- Partial agonists

Functional Opioid Pharmacology

- Derivation from Opium
- Semi synthetic
- Synthetic

Functional Opioid Pharmacology

- Brain Regions:
  - Pain
  - Reward/Reinforcement
  - Arousal
  - Memory
  - Emotional control

Functional Opioid Pharmacology

- Medical Indications:
  - Analgesia
  - Cough suppression
  - Antidiarrheal / Antispasmodic

Epidemiology / Demographics

Definition

- Distribution and determinants of opioid addiction in populations
- Prevalence
- Incidence
- Casual factors
- Social characteristics

Prevalence/Incidence/Trends

- NHSDA
- Monitoring the Future Survey
- CEWG
- Pulse Check
- DAWN
- DEA reports

Changing Face of Opioid Addiction

OXYCONTIN

OxyContin

- ~92 deaths in 2001, eight-county Philadelphia region
- In 2000, Philadelphia Medical Examiner's Office found 41 cases
- DEA announced in April, 2002, OxyContin may have played a role in 464 deaths across the US in 2000-01
- Multiple Substance Use

Multiple Substance Abuse

Multiple Substance Abuse

- Prevalence
- Patterns of use
- Reasons for use
- Implications for treatment

Polysubstance Abuse

Prevalence Rates

- **Alcohol - 20 - 30%**
- **Benzodiazepines - 45 - 65%**
- **Cocaine**
  - **Baltimore (Kolar et al, 1990) - 6 - 33%**
  - **8 States (GAO Report, 1990) - 0 - 40%**
  - **San Francisco (Chaisson et al, 1989) - 62%**
- **Marijuana**
  - **DuPont & Snyder (2 programs) 27%, 51%**
- **Nicotine**
  - **General Population 28%**
  - **Anxiety and Personality Disorders 45 - 49%**
  - **Alcoholics >80%**

Patterns of Use

- Heroin / Cocaine "speedball"
- Heroin / Benzodiazepines
- Heroin / Alcohol
- Clonidine
- Amitriptyline

Reasons for Use

- Social / Recreational
- Synergism with Methadone ("boost")
- Treat medical problems (chronic pain)
- Treat psychiatric symptoms
- Treat withdrawal symptoms

Implications for Treatment

- (+) Pre-treatment history indicates poor prognostic outcome
  - Higher frequency and intensity of services
  - Intensive Outpatient Treatment
  - Partial Hospitalization
  - Inpatient Treatment
  - Pharmacotherapeutic options limited

Abstinence and Recovery

Definitional Understanding

- Abstinence:
  - To refrain from voluntary use
  - Substance free
  - "Clean"

Definitional Understanding

- Recovery:
  - Abstinence, requirement
  - "Drug free"
  - Qualitative state of existence
  - Concept commonly not associated with Methadone

Patient Profiles of Recovery

Comprehensive MAT

Levels of Care

- Medication Assisted Treatment at all levels of care
  - Medical Necessity Guidelines
  - ASAM PPC
  - PCPC

Future Directions

Future Directions

- Access
- Expansion
- New medications
- Mainstream medicine
- Outcome studies
- Public health concerns

Access / Expansion

- IOM Study
- NIH Consensus Recommendations
- CSAT / SAMHSA

New Medications

- Buprenorphine
- LAAM

Mainstream Medicine

- Primary Care
- Health System Integration
- Physician and Practitioner Education

Outcome Studies

- Treatment Retention
- Substance Use
- Functional Measures
  - Physical Health
  - Mental Health
  - Psychosocial Wellness
  - Employment
  - Housing

Public Health Concerns

- HIV
- Hepatitis C, B

NATIONAL DRUG COURT INSTITUTE

DRUG COURT PRACTITIONER FACT SHEET

Karen Freeman-Wilson, Executive Director *April 2002* *Vol. III, No. 1*

Methadone Maintenance and Other Pharmacotherapeutic Interventions in the Treatment of Opioid Dependence

Overview

Drug Courts are being confronted with increasing numbers of opiate dependent offenders. From heroin to oxycontin, opioid dependence is a devastating reality facing many drug courts throughout the nation. Although opioid addiction presents many new challenges, it is a treatable disease with evidence-based treatment responses. This Fact Sheet is intended to dispel misperceptions and educate practitioners about the efficacy of medication assisted treatment.

According to the Office of National Drug Control Policy, there were over 977,000 heroin dependent individuals in the United States in the year 2000. The Substance Abuse and Mental Health Services Administration's 2000 National Household Survey on Drug Abuse indicated that an estimated 104,000 persons used heroin for the first time in 1999.

There has been an increasing trend in new heroin use since 1991. A significant proportion of these recent new users were smoking, snorting or sniffing heroin. Most of these new users are under the age of 26 (SAMHSA/U.S. Department of Health and Human Services). According to SAMHSA's 2000 National Household Survey on Drug Abuse, the average age of first heroin use has steadily declined since 1989, from 24 to 19 years of age in 1999. The "Monitoring the Future" study indicated that approximately 1.4% of our nation's 10th grade students used heroin in 1998.

According to the DEA's Domestic Monitoring Program data, the national average for heroin purity has remained relatively stable (above 35% per pure milligram) since 1992. An analysis of these same data also indicate a steady decline in the average price per milligram for heroin since 1992 at both the retail and dealer level. According to 1999 FBI Uniform Crime Reports, arrests for drug abuse violations have steadily increased since 1991. There were 1.56 million drug-related arrests in 1998.

The Substance Abuse and Mental Health Services Administration's (SAMHSA) 2000 Emergency Department Data from the Drug Abuse Warning Network (DAWN) identified an increase in heroin/morphine mentions between 1999 and 2000 in eight of the 21 metropolitan areas in the reporting network.

Methadone Maintenance Treatment

Methadone is the most widely studied medication and treatment for any disease in the world. Opioid treatment programs provide the dependent individual with an array of rehabilitative services. Therapeutically prescribed doses of methadone and LAAM relieve withdrawal symptoms eliminate opiate craving and allow normal functioning. The efficacy of these medications increases significantly with counseling and on-site medical and other supportive treatment services. Medical personnel supervise treatment and nurses administer the medication to patients, most typically on a daily regimen until the individual is stabilized. Patients also provide toxicology samples, which are tested for the presence of methadone and drugs of abuse.

Methadone has been used to treat opioid dependence for thirty-five years and like all medications, therapeutic dosing is contingent upon individual patient needs. The therapeutic dosage range is generally between 80 – 120 mg. Methadone is taken orally and is rapidly absorbed from the gastrointestinal tract, appearing in plasma within thirty minutes of being ingested. Methadone is also widely distributed to body tissues where it is stored and then released into the plasma. This combination of storage and release keeps the patient comfortable, free from craving, and feeling stable.

The General Accounting Office reported in 1990 that "The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, the federal government's two primary agencies for researching drug and alcohol abuse issues, respectively, have concluded that methadone is the most effective method available for treating heroin addiction."

SAMHSA's Center for Substance Abuse Treatment (CSAT) has also reported the increasing use of oxycontin and that methadone maintenance treatment is an effective pharmacotherapeutic intervention if oxycontin dependent individuals meet existing federal admission criteria. A significant number of oxycontin dependent individuals were admitted to methadone treatment programs during 2001 and have improved with a stable medication treatment regimen, in addition to counseling and other medical services.

This fact sheet was prepared by Mark W. Parrino, M.P.A., President, American Association for the Treatment of Opioid Dependence. Laura McNicholas, M.D., Ph.D., Director of CESATE, Philadelphia Veterans Administration Medical Center, prepared the sections on Buprenorphine and LAAM. This document was published with support from the Office of National Drug Control Policy, Executive Office of the President.

The Center for Substance Abuse Treatment has found, as of October, 2001, that more than 205,000 individuals are being treated in methadone treatment programs. The National Institutes of Health Consensus Development Conference on "Effective Medical Treatment of Opiate Addiction" (November 1997) concluded that it is necessary to increase access to methadone treatment services throughout the United States and to increase funding for methadone treatment, including providing benefits to methadone patients as part of public and private health insurance programs.

The Pharmacology of Methadone Treatment

Some critics of methadone treatment believe that it represents substituting one drug for another. Such critics see no distinction between heroin as an illicit drug and methadone as a medication, which is used in conjunction with other treatment services. Research has proven the drug substituting assertion to be false. Heroin and methadone have completely different pharmacologic properties.

Heroin has an immediate onset of action with a four to six hour duration. The route of administration is typically through injection, snorting or smoking several times each day. Very few individuals can achieve any kind of neurochemical stability through such a short-acting opiate.

Methadone is taken once per day and has a duration of action of between 24 and 36 hours. It is orally ingested and is released into the body over the course of time through the liver. This is why methadone maintenance does not cause euphoric effects in the stabilized patient.

Other critics of methadone treatment include people in recovery from other drugs of abuse, including alcohol. They claim that since they are able to be abstinent without pharmacotherapy that methadone maintenance does not represent a "true" state of recovery. Once again, science does not support this view. The National Institute on Drug Abuse has found through years of research that there are profound changes in the chemistry of the brain as a result of chronic use of exogenous opiates such as heroin. The biology of the brain changes and may never revert back to its pre-heroin use state for a number of heroin-dependent individuals. While this may not apply to all heroin-dependent persons, it has been found that more than 80% of methadone maintained patients will relapse to heroin use when methadone maintenance is withdrawn within the first 12 months of treatment being terminated.

Methadone and Pregnancy

Women can conceive and have normal pregnancies and deliveries when maintained on methadone. When the methadone dosage is therapeutically prescribed for pregnant women, methadone treatment provides a non-stressful environment for the developing fetus. Because methadone crosses the placental barrier, some babies born to female methadone patients may be physically dependent on methadone at first and need to be weaned. It is also true that methadone maintained women give birth to babies who do not experience any withdrawal. The myth that methadone produces abnormality in fetuses has no basis in fact. Additionally, children born to methadone maintained women have been studied longitudinally and develop normally in good post natal environments. Accordingly, it is medically contraindicated to withdraw pregnant methadone maintained patients.

Federal Oversight of Methadone Treatment

The Center for Substance Abuse Treatment within SAMHSA manages the new accreditation system for methadone treatment programs. Implemented on May 18, 2001, this system will ensure that every methadone maintenance treatment program in the country is accredited over the course of the next three years, providing better program accountability and improving treatment quality throughout the nation's 950 registered methadone treatment programs. All treatment programs, regardless of the source of their funding (private or nonprofit) will be subject to these quality-driven accreditation standards.

Impact of Methadone Treatment in Reducing HIV Infection, Treating Hepatitis C and Psychiatric Comorbidity

Studies of methadone treatment have consistently found dramatic declines in heroin use after admission to methadone treatment and further declines as the patient remains in treatment. The value of treatment retention cannot be overstated.

The relationship between intravenous drug use, needle sharing and HIV/AIDS exposure is also well documented Methadone treatment has played a pivotal role in reducing the spread of HIV/AIDS, according to NIDA-funded studies.

We also know that more than 70% of methadone maintained patients across the country are HCV-positive. Accordingly, methadone treatment programs are providing support services to these patients, ensuring that they are followed for HCV in addition to other comorbidities.

There is also significant psychiatric comorbidity in the methadone treated population, cited in the Ball & Ross study "The Effectiveness of Methadone Maintenance Treatment", published in 1991. The study found a lifetime prevalence of serious depression and anxiety disorders in 48% of the patients in the study. Methadone treatment programs are able to treat such psychiatric comorbidity either through the methadone treatment program or by referral to psychiatric services.

Impact of Methadone Treatment in Reducing Crime/Cost Effectiveness

Methadone treatment is also associated with reducing crime in the offender population as patients enter and remain in treatment. It has been repeatedly demonstrated that 80% of the patients will reduce or eliminate crime as they remain in methadone treatment programs.

The cost savings to taxpayers are also well documented. A comprehensive examination of the economic benefits and cost of methadone treatment reveals the benefits to cost ratio at 4:1; $4.00 in economic benefits for every $1.00 spent.

The Institute of Medicine concluded that "methadone maintenance pays for itself on the day it is delivered, and post treatment effects are an economic bonus." The average cost of outpatient methadone treatment is approximately $5,000.00 per year and involves the use of medication in addition to medical care and counseling.

Methadone treatment programs are staffed by professionals with extensive medical, clinical and administrative expertise. Patients routinely meet with a primary counselor, attend clinic groups and access medical and social services within the program setting.

Methadone Treatment in Correctional Settings

According to NIDA's October 1999 "Principles of Drug Addiction Treatment": "Research is demonstrating that treatment for drug addicted offenders during and after incarceration can have a significant beneficial effect upon future drug use, criminal behavior and social functioning. The case for integrating drug addiction treatment approaches within the Criminal Justice system is compelling. Combining prison and community-based treatment for drug addicted offenders reduces the risk of both recidivism to drug-related criminal behavior and relapse to drug use."

At present, Rikers Island in New York City is the only correctional system in the United States that treats heroin dependent inmates with methadone, referring them to treatment programs upon release. The intervention is called the Key Extended Entry Program (KEEP) and has been a part of the Rikers Island Health Services since 1987. The service combines pharmacotherapy and comprehensive therapeutic treatment.

The Rikers Island program treated 3,985 inmates with methadone in 2000. Approximately 70% of these inmates were men and 10% of the women in the program were pregnant. All inmates have been diagnosed as opiate dependent by medical staff and were charged with either a misdemeanor or low grade felony, serving a misdemeanor sentence in order to qualify for the program. 76% of all inmate patients reported to their assigned programs for continued substance abuse treatment following their release from jail.

The average KEEP patient's length of stay was 35 days at Rikers Island in 2000. The program has demonstrated statistically significant differences in decreased criminal recidivism. It makes sense to expand access to this kind of service for people under legal supervision, especially since Drug Courts sanction drug dependent individuals to correctional facilities for short periods of time. Consideration might be given to reframing the Rikers Island KEEP program as a "reentry" program so that heroin dependent individuals can gain access to methadone treatment services upon release from incarceration.

A number of correctional facilities have indicated an interest in using pharmacotherapeutic interventions in treating chronic opiate dependence, based on the success of the Rikers Island model. Additionally, such correctional facilities have been using Naltrexone and are likely to consider using Buprenorphine, when it is approved. The Rikers Island experience indicates that providing access to such medication assisted treatment in correctional facilities is an extremely effective method of reducing recidivism and ensuring that people get access to outpatient services when they are released from jail.

Buprenorphine

Buprenorphine is a partial agonist of the mu-opioid receptor that is currently in development for the treatment of opioid dependence. When available, it will be marketed as sublingual (SL) tablets. Two forms of buprenorphine will be available – buprenorphine alone in 2 and 8 mg tablets and a combination of buprenorphine and naloxone as sublingual tablets containing 2mg of buprenorphine and 0.5 mg of naloxone or 8 mg of buprenorphine and 2 mg of naloxone.

As a partial agonist, rather than a full agonist such as methadone or morphine, buprenorphine has pharmacological properties that are similar to but different from those of methadone. It has a ceiling effect for most of the effects produced by opioid drugs, such as analgesia and respiratory depression. This makes buprenorphine safer, in terms of respiratory depression in case of an overdose, but also may limit its efficacy for some patients. From a variety of studies. in opioid-dependent patients, it has been shown that buprenorphine, 4 – 8 mg SL, is as effective as 30 mg of methadone in suppressing opioid withdrawal signs and symptoms for approximately 24 hours.

For maintenance therapy, approximately 16 mg of buprenorphine SL is equal to approximately 65 mg of methadone. Further, buprenorphine is thought to occupy the opioid receptor for much longer than other agonists, such as methadone, and is very firmly bound to the receptor, making it difficult for other opiates to displace it. For these reasons, buprenorphine works very well for some or most patients who need agonist maintenance therapy. However, patients who require high agonist doses for stabilization may not be adequately treated with buprenorphine.

Further, for patients who are currently maintained on methadone or LAAM, it will not be appropriate or, often, possible to switch patients to buprenorphine. Because of the partial agonist qualities of buprenorphine, patients cannot simply be switched over from methadone to buprenorphine; the patient must first be stabilized on a daily dose of methadone of no more than 30 mg, then switched to buprenorphine. It must be remembered that many patients on higher doses of methadone have a great deal of difficulty decreasing the daily methadone dose while maintaining stability in treatment.

When available, buprenorphine will be marketed as both the mono form and in combination with naloxone. The reason for the combination is that when buprenorphine has become available and distributed in the mono form, it has been abused. While buprenorphine, as a partial agonist, has a lower abuse potential than full agonists, it does have opioid effects and can be abused. In places where the medication has been abused, it has been by the injection, not the sublingual, route of administration. Naloxone is not readily available when taken by the sublingual route, but is readily available when injected. It is thought that adding the naloxone to the sublingual tablet will decrease diversion and abuse by the injection route. Studies have shown that the combination tablet is as effective in clinical trials as the mono form of SL buprenorphine.

LAAM

LAAM, levomethadyl acetate, is a long-acting mu-opioid agonist. It acts much like methadone in the treatment of opioid dependence, but offers some advantages for some patients. Because LAAM undergoes extensive metabolism to active and long-lasting metabolites in the liver, it can be dosed less than daily. Most patients will receive LAAM only on a thrice-weekly schedule, allowing better functioning in the workplace or in the family situation. While LAAM offers some advantages for some patients in terms of dosing frequency, it has recently been associated with cardiac side effects. It has been shown that LAAM may prolong the Q-T interval in some patients and, in order to prevent medical complications, patients must be monitored with ECGs before and during their treatment with LAAM.

Summary

Methadone medication is not a substitute for heroin and does not affect the individual in any similar way. Methadone treatment has been rigorously studied for more than 35 years and the results are found to be uniformly positive.

Accreditation oversight will enhance the consistency and quality of treatment services throughout the nation's methadone treatment programs. It is expected to end the debate about the quality of care offered in publicly funded vs. privately financed treatment programs since all programs, public and private, will be accredited through CSAT's approved accrediting organizations.

While a number of people will continue to be critical of methadone treatment because the medication, as a pharmacotherapeutic agonist, has its own dependence producing qualities, the reality is that we do not have anything at the present time (including Buprenorphine), following years of exhaustive research by NIDA, that will be able to perform as methadone maintenance treatment does in normalizing brain function without having some dependency-producing characteristics.

Just as psychiatrists are not expected to withdraw depressed patients from their antidepressant medication and, as physicians do not withdraw their patients from cardiovascular or other life sustaining medications that stabilize the patient and enable him/her to lead a normal life without struggling through the debilitating effects of an illness, methadone patients should not be required to withdraw from a medication that improves their quality of life.

Heroin dependence is a form of addictive disease, and methadone maintenance is a well-researched therapeutic medication. The empirical evidence consistently supports its safety and efficacy. Methadone and alternative pharmacotherapeutic agents alone are not sufficient; they must be combined with other therapeutic services to be of value to the individual. It is important that the criminal justice system strengthen its commitment to evidence-based treatment and work to address ideological biases through continuing education.

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U.S. Department of Health and Human Services. (1993). *State methadone treatment guidelines.* DHHS Publication No. (SMA) 93-1991. Washington, DC: Author.

Resources/Contacts

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Methadone Maintenance Treatment (MMT):

A Review of Historical and Clinical Issues

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Abstract

Methadone maintenance has been evaluated since its development in 1964 as a medical response to the post-World War II heroin epidemic in New York City. The findings of major early studies have been consistent. Methadone maintenance reduces and/or eliminates the use of heroin, reduces the death rates and criminality associated with heroin use, and allows patients to improve their health and social productivity. In addition, enrollment in methadone maintenance has the potential to reduce the transmission of infectious diseases associated with heroin injection, such as hepatitis and HIV. The principal effects of methadone maintenance are to relieve narcotic craving, suppress the abstinence syndrome, and block the euphoric effects associated with heroin. A majority of patients require 80–120 mg/d of methadone, or more, to achieve these effects and require treatment for an indefinite period of time, since methadone maintenance is a corrective but not a curative treatment for heroin addiction. Lower doses may not be as effective or provide the blockade effect. Methadone maintenance has been found to be medically safe and nonsedating. It is also indicated for pregnant women addicted to heroin.

Reviews issued by the Institute of Medicine and the National Institutes of Health have defined narcotic addiction as a chronic medical disorder and have claimed that methadone maintenance coupled with social services is the most effective treatment for this condition. These agencies recommend reducing governmental regulation to facilitate patients' access to treatment. In addition, they recommend that the number of programs be expanded, and that new models of treatment be implemented, if the nationwide problem of addiction is to be brought under control. The National Institutes of Health also recommend that methadone maintenance be available to persons under legal supervision, such as probationers, parolees and the incarcerated.

However, stigma and bias directed at the programs and the patients have hindered expansion and the effective delivery of services. Professional community leadership is necessary to educate the general public if these impediments are to be overcome.

Key Words: Methadone maintenance, heroin addiction, history, pregnancy, evaluation, HIV, hepatitis C.

Introduction

THE PURPOSE OF THIS PAPER is to review historical and clinical issues, basic studies, evaluations, and procedures that led to the development and expansion of methadone maintenance treatment for heroin addiction. This review concentrates on the early development of the program and factors leading to its success and acceptance. From its inception, methadone maintenance treatment has been studied for medical safety and efficacy. The studies investigated not only medical and clinical issues but also the social factors (such as employment and criminality) that affect patient adjustment to the program.

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Historical Background of Methadone Maintenance Treatment

Intravenous abuse of heroin intensified in New York City after World War II and, by the 1950s and 1960s, reached epidemic proportions (1, 2). From 1964 to 1970, the names of more than 151,000 addicted persons were reported to the Narcotics Register of the New York City Department of Health (2). Between 1950 and 1961, the death rate associated with the injection of heroin increased from 7.2 per 10,000 deaths to 35.8 per 10,000 deaths, with 75% of the deaths in the 15–35-year-old age group. During this interval, death related to heroin injection became the leading cause of death in New York City for young adults. The average age of death from heroin-related use was 29 years for both sexes (3).

Methadone, a long-acting agonist with a half-life of about 24 to 36 hours, was synthesized for analgesia prior to World War II in Germany. In 1949, Isbell and Vogel, working at the U.S. Public Health Hospital in Lexington, Kentucky, showed methadone to be the most effective medication for withdrawing addicts from heroin (4). The proce-

nationwide. To increase accessibility to treatment, both agencies recommend the expansion of methadone maintenance, the training of more health personnel, the easing of regulations on federal, state and local levels to permit the opening of new programs, and the development of new models of treatment. However, effective medical and political leadership is necessary to reduce the social stigma surrounding addiction and methadone treatment in order to effectively implement these changes.

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The Neurobiology of Opioid Dependence: Implications for Treatment

Opioid tolerance, dependence, and addiction are all manifestations of brain changes resulting from chronic opioid abuse. The opioid abuser's struggle for recovery is in great part a struggle to overcome the effects of these changes. Medications such as methadone, LAAM, buprenorphine, and naltrexone act on the same brain structures and processes as addictive opioids, but with protective or normalizing effects. Despite the effectiveness of medications, they must be used in conjunction with appropriate psychosocial treatments.

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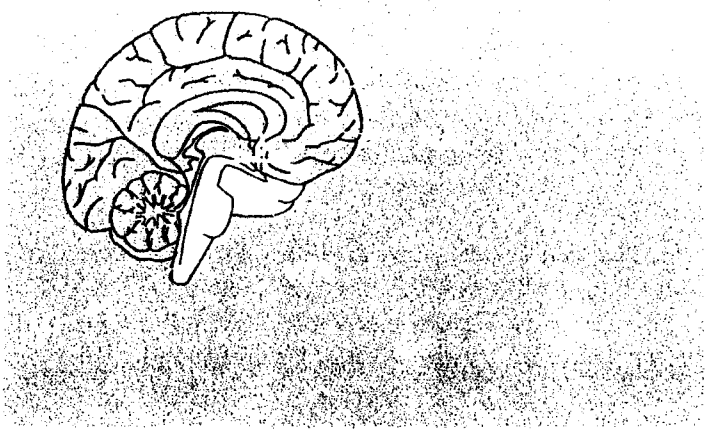
While the individual patient, rather than his or her disease, is the appropriate focus of treatment for opioid abuse, an understanding of the neurobiology of dependence and addiction can be invaluable to the clinician. It can provide insight about patient behaviors and problems, help define realistic expectations, and clarify the rationales for treatment methods and goals. As well, patients who are informed about the brain origins of addiction can benefit from understanding that their illness has a biological basis and does not mean they are "bad" people.

Brain abnormalities resulting from chronic use of heroin, oxycodone, and other morphine-derived drugs are underlying causes of opioid dependence (the need to keep taking drugs to avoid a withdrawal syndrome) and addiction (intense drug craving and compulsive use). The abnormalities that produce dependence, well understood by science, appear to resolve after detoxification, within days or weeks after opioid use stops. The abnormalities that produce addiction, however, are more wide-ranging, complex, and long-lasting. They may involve an interaction of environmental effects—for example, stress, the social context of initial opiate use, and psychological conditioning—and a genetic predisposition in the form of brain pathways that were abnormal even before the first dose of opioid was taken. Such abnormalities can produce craving that leads to relapse months or years after the individual is no longer opioid dependent.

In this article we describe how opioids affect brain processes to produce drug liking, tolerance, dependence, and addiction. While these processes, like everything else that happens in the brain, are highly complex, we try to explain them in terms that can be easily understood and explained to patients. We also discuss

FIGURE 1. The Mesolimbic Reward System



When drugs stimulate mu opioid receptors in the brain, cells in the ventral tegmental area (VTA) produce dopamine and release it into the nucleus accumbens (NAc), giving rise to feelings of pleasure. Feedback from the prefrontal cortex (PFC) to the VTA helps us overcome drives to obtain pleasure through actions that may be unsafe or unwise, but this feedback appears to be compromised in individuals who become addicted to drugs. The locus ceruleus (LC) is an area of the brain that plays an important role in drug dependence.

Patients can benefit from understanding that their addiction has a biological basis.

the treatment implications of these concepts. Pharmacological therapy with methadone, LAAM (levo-alpha-acetylmethadol), naltrexone, or other medications directly offsets or reverses some of the brain changes associated with addiction, greatly enhancing the effectiveness of behavioral therapies. Although researchers do not yet know everything about how these medications work, it is clear that they are all truly active treatments, rather than simply substitutes for the addictive opioids.

ORIGINS OF DRUG LIKING

Many factors, both individual and environmental, influence whether a particular person who experiments with opioid drugs will continue taking them long enough to become dependent or addicted. For individuals who do continue, the opioids' ability to provide intense feelings of pleasure is a critical reason.

When heroin, oxycodone, or any other opiate travels through the bloodstream to the brain, the chemicals attach to specialized proteins, called mu opioid receptors, on the surfaces of opiate-sensitive neurons (brain cells). The linkage of these chemicals with the receptors triggers the same biochemical brain processes that reward people with feelings of pleasure when they engage in activities that promote basic life functions, such as eating and sex. Opioids are prescribed therapeutically to relieve pain, but when opioids activate these reward processes in the absence of significant pain, they can motivate repeated use of the drug simply for pleasure.

One of the brain circuits that is activated by opioids is the mesolimbic (midbrain) reward system. This system generates signals in a part of the brain called the ventral tegmental area (VTA) that result in the release of the chemical dopamine (DA) in another part of the brain, the nucleus accumbens (NAc) (Figure 1). This release of DA into the NAc causes feelings of pleasure. Other areas of the brain create a lasting record or memory that associates these good feelings with the circumstances and environment in which they occur. These memories, called conditioned associations, often lead to the craving for drugs when the abuser reencounters those persons, places, or things, and they drive abusers to seek out more drugs in spite of many obstacles.

Particularly in the early stages of abuse, the opioid's stimulation of the brain's reward system is a primary reason that some people take drugs repeatedly. However, the compulsion to use opioids builds over time to extend beyond a simple drive for pleasure. This increased compulsion is related to tolerance and dependence.

OPIOID TOLERANCE, DEPENDENCE, AND WITHDRAWAL

From a clinical standpoint, opioid withdrawal is one of the most powerful factors driving opioid dependence and addictive behaviors. Treatment of the patient's withdrawal symptoms is based on understanding how withdrawal is related to the brain's adjustment to opioids.

Repeated exposure to escalating dosages of opioids alters the brain so that it functions more or less normally when the drugs are present and abnormally when they are not. Two clinically important results of this alteration are opioid tolerance (the need to take higher and higher dosages of drugs to achieve the same opioid effect) and drug dependence (susceptibility to withdrawal symptoms). Withdrawal symptoms occur only in patients who have developed tolerance.

Opioid tolerance occurs because the brain cells that have opioid receptors on them gradually become less responsive to the opioid stimulation. For example, more opioid is needed to stimulate the VTA brain cells of the mesolimbic reward system to release the same amount of DA in the NAc. Therefore, more opioid is needed to produce pleasure comparable to that provided in previous drug-taking episodes.

Opioid dependence and some of the most distressing opioid withdrawal symptoms stem from changes in another important brain system, involving an area at the base of the brain—the locus ceruleus (LC) (Figure 2). Neurons in the LC produce a chemical, noradrenaline (NA), and distribute it to other parts of the brain where it stimulates wakefulness, breathing, blood pressure, and general alertness, among other functions. When opioid molecules link to mu receptors on brain cells in the LC, they suppress the neurons' release of NA, resulting in drowsiness, slowed respiration, low blood pressure—familiar effects of opioid intoxication. With repeated exposure to opioids, however, the LC neurons adjust by increasing their level of activity. Now, when opioids are present, their suppressive impact is offset by this heightened activity, with the result that roughly normal amounts of NA are released and the patient feels more or less normal. When opioids are not present to suppress the LC brain cells' enhanced activity, however, the neurons release excessive amounts of NA, triggering jitters, anxiety, muscle cramps, and diarrhea.

Other brain areas in addition to the LC also contribute to the production of withdrawal symptoms, including the mesolimbic reward system. For example, opioid tolerance that reduces the VTA's release of DA into the NAc may prevent the patient from obtaining pleasure from normally rewarding activities such as eating. These changes in the VTA and the DA reward systems, though not fully understood, form an important brain system underlying craving and compulsive drug use.

TRANSITION TO ADDICTION

As we have seen, the pleasure derived from opioids' activation of the brain's natural reward system promotes continued drug use during the initial stages of opioid addiction. Subsequently, repeated exposure to opioid drugs induces the brain mechanisms of dependence, which leads to daily drug use to avert the unpleasant symptoms of drug withdrawal. Further prolonged use produces more long-lasting changes in the brain that may underlie the compulsive drug-seeking behavior and related adverse consequences that are the hallmarks of addiction. Recent scientific research has generated several models to explain how habitual drug use produces changes in the brain that may lead to drug addiction. In reality, the process of addiction probably involves components from each of these models, as well as other features.

Definitions of Key Terms

dopamine (DA): A neurotransmitter present in brain regions that regulate movement, emotion, motivation, and the feeling of pleasure.

GABA (gamma-amino butyric acid): A neurotransmitter in the brain whose primary function is to inhibit the firing of neurons.

locus ceruleus (LC): A region of the brain that receives and processes sensory signals from all areas of the body; involved in arousal and vigilance.

noradrenaline (NA): A neurotransmitter produced in the brain and peripheral nervous system; involved in arousal and regulation of blood pressure, sleep, and mood; also called norepinephrine.

nucleus accumbens (NAc): A structure in the forebrain that plays an important part in dopamine release and stimulant action; one of the brain's key pleasure centers.

prefrontal cortex (PFC): The frontmost part of the brain; involved in higher cognitive functions, including foresight and planning.

ventral tegmental area (VTA): The group of dopamine-containing neurons that make up a key part of the brain reward system; key targets of these neurons include the nucleus accumbens and the prefrontal cortex

The "Changed Set Point" Model

The "changed set point" model of drug addiction has several variants based on the altered neurobiology of the DA neurons in the VTA and of the NA neurons of the LC during the early phases of withdrawal and abstinence. The basic idea is that drug abuse alters a biological or physiological setting or baseline. One variant, by Koob and LeMoal (2001), is based on the idea that neurons of the mesolimbic reward pathways are naturally "set" to release enough DA in the NAc to produce a normal level of pleasure. Koob and LeMoal suggest that opioids cause addiction by initiating a

vicious cycle of changing this set point such that the release of DA is reduced when normally pleasurable activities occur and opioids are not present. Similarly, a change in set point occurs in the LC, but in the opposite direction, such that NA release is increased during withdrawal, as described above. Under this model, both the positive (drug liking) and negative (drug withdrawal) aspects of drug addiction are accounted for.

Opioid tolerance occurs because the brain cells gradually become less responsive to the opioid stimulation.

A specific way that the DA neurons can become dysfunctional relates to an alteration in their baseline ("resting") levels of electrical activity and DA release (Grace, 2000). In this second variant of the changed set point model, this resting level is the result of two factors that influence the amount of resting DA release in the NAc: cortical excitatory (glutamate) neurons that drive the VTA DA neurons to release DA, and autoreceptors ("brakes") that shut down further release when DA concentrations become excessive. Activation of opioid receptors by heroin and heroin-like drugs initially bypasses these brakes and leads to a large release of DA in the NAc. However, with repeated heroin use, the brain responds to these successive large DA releases by increasing the number and strength of the brakes on the VTA DA neurons. Eventually, these enhanced "braking" autoreceptors inhibit the neurons' resting DA release. When this happens, the dependent addict will take even more heroin to offset the reduction of normal resting DA release. When he or she stops the heroin use, a state of DA deprivation will result, manifesting in dysphoria (pain, agitation, malaise) and other withdrawal symptoms, which can lead to a cycle of relapse to drug use.

A third variation on the set-point change emphasizes the sensitivity to environmental cues that leads to drug wanting or craving rather than just reinforcement and withdrawal (Breiter et al., 1997; Robinson and Berridge, 2000). During periods when the drug is not available to addicts, their brains can remember the drug, and desire or craving for the drug can be a major factor leading to drug use relapse. This craving may represent increased activity of the cortical excitatory (glutamate) neurotransmitters, which drive the resting activity of the DA-containing VTA neurons, as mentioned, and also drive the LC NA neurons. As the glutamate activity increases, DA will be released from the VTA, leading to drug wanting or craving, and NA will be released from the LC, leading to increased opioid withdrawal symptoms. This theory suggests that these cortical excitatory brain pathways are overactive in heroin addiction and that reducing their activity would be therapeutic. Scientists are currently researching a medication called lamotrigene and related compounds called excitatory amino acid antagonists to see whether this potential treatment strategy really can work.

Thus, several mechanisms in the LC and VTA-NAc brain pathways may be operating during addiction and relapse. The excitatory cortical pathways may produce little response in the VTA during the resting state, leading to reductions in DA. However, when the addicted individual is exposed to cues that produce craving, the glutamate pathways may get sufficiently active to raise DA and stimulate desire for a greater high. This same increase in glutamate activity will raise NA release from the LC to produce a dysphoric state predisposing to relapse and continued addiction.

Cognitive Deficits Model

The cognitive deficits model of drug addiction proposes that individuals who develop addictive disorders have abnormalities in an area of the brain called the prefrontal cortex (PFC). The PFC is important for regulation of judgment, planning, and other executive functions. To help us overcome some of our impulses for immediate gratification in favor of more important or ultimately more rewarding long-term goals, the PFC sends inhibitory signals to the VTA DA neurons of the mesolimbic reward system.

The cognitive deficits model proposes that PFC signaling to the mesolimbic reward system is compromised in individuals with addictive disorders, and as a result they have reduced ability to use judgment to restrain their impulses and are predisposed to compulsive drug-taking behaviors. Consistent with this model, stimulant drugs such as methamphetamine appear to damage the specific brain circuit—the fronto-striatal loop—that carries inhibitory signals from the PFC to the mesolimbic reward system. In addition, a recent study using magnetic resonance spectroscopy showed that chronic alcohol abusers have abnormally low levels of gamma-amino butyric acid (GABA), the neurochemical that the PFC uses to signal the reward system to release less DA (Behar et al., 1999). As well, the cognitive deficits model of drug addiction could explain the clinical observation that heroin addiction is more severe in individuals with antisocial personality disorder—a condition that is independently associated with PFC deficits (Raine et al., 2000).

FIGURE 2. The Neurobiological Basis of Dependence and Withdrawal

The locus ceruleus (LC) is an area of the brain that is critically involved in the production of opioid dependence and withdrawal. The diagrams show how opioid drugs affect processes in the LC that control the release of noradrenaline (NA), a brain chemical that stimulates wakefulness, muscle tone, and respiration, among other functions.

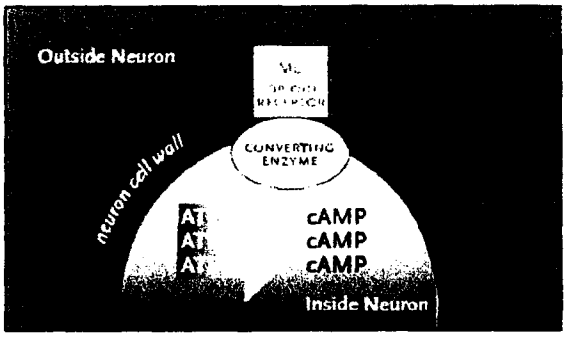
A. Normally, natural opiatelike chemicals produced by the body link to mu opioid receptors on the surface of neurons. This linkage activates an enzyme that converts a chemical called adenosine triphosphate (ATP) into another chemical, called cyclic adenosine monophosphate (cAMP), which in turn triggers the release of NA. Prior to initiation of opioid drug abuse, the neuron produces enough NA to maintain normal levels of alertness, muscle tone, respiration, etc.

B. When heroin or another opioid drug links to the mu opioid receptors, it inhibits the enzyme that converts ATP to cAMP. As a result, less cAMP is produced, less NA is released. Alertness, muscle tone, and respiration drop, and the acute opioid effects of sedation, shallow breathing, etc., appear.

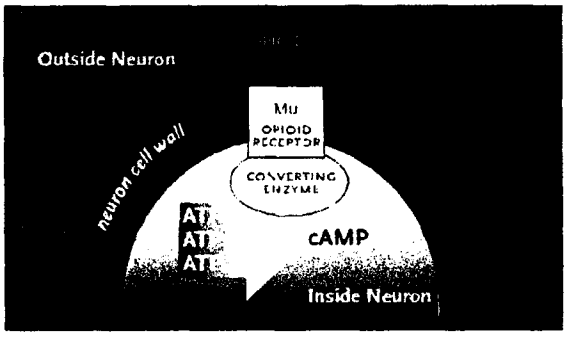
C. With repeated heroin exposure, the neuron increases its supply of enzyme and ATP molecules. Using these extra raw materials, the neuron can produce enough cAMP to offset the inhibitory effect of the drug and release roughly normal amounts of NA despite the presence of the drug. At this stage, the individual no longer experiences the same intensity of acute opioid effects as in earlier stages of abuse.

D. When heroin is discontinued after chronic abuse, the drug's inhibitory impact is lost. Operating at normal efficiency but with enhanced supplies of converting enzyme and ATP, the neuron produces abnormally high levels of cAMP, leading to excessive release of NA. The patient experiences the clinical symptoms of withdrawal—jitters, anxiety, muscle cramps, etc. If no further drugs are taken, the neuron will largely revert to its predrug condition (panel A) within days or weeks.

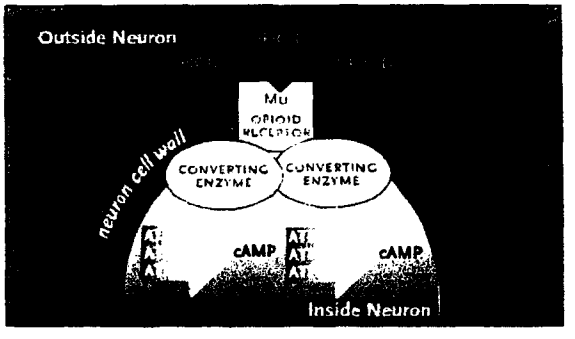
A. Baseline: Normal production of NA



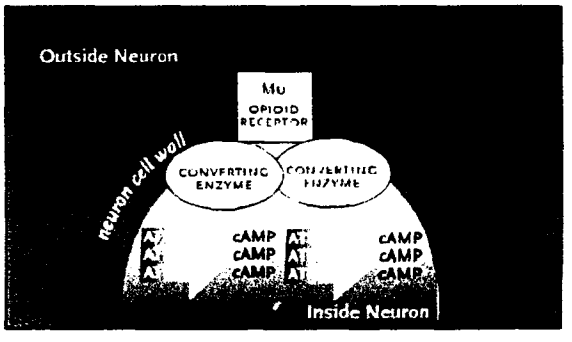
B. Acute opioid inhibition of converting enzyme: Abnormally low production of NA



C. Chronic opioid inhibition leads to increased converting enzyme activity: Normal NA level



D. Discontinuing opioid leads to increased cyclic AMP due to loss of inhibition: NA excessively high



Repeated exposure to opioid drugs induces the brain mechanisms of dependence, which leads to daily drug use to avert the unpleasant symptoms of drug withdrawal.

Methadone causes dependence, but—because of its steadier influence on the mu opioid receptors—it produces minimal tolerance and alleviates craving and compulsive drug use.

In contrast to stimulants, heroin apparently damages the PFC but not the fronto-striatal loop. Therefore, individuals who become heroin addicts may have some PFC damage that is independent of their opioid abuse, either inherited genetically or caused by some other factor or event in their lives. This preexisting PFC damage predisposes these individuals to impulsivity and lack of control, and the additional PFC damage from chronic repeated heroin abuse increases the severity of these problems (Kosten, 1998).

STRESS AND DRUG CRAVING

That drug abuse patients are more vulnerable to stress than the general population is a clinical truism. In the research arena, numerous studies have documented that physical stressors (such as footshock or restraint stress) and psychological stressors can cause animals to reinstate drug use and that stressors can trigger drug craving in addicted humans (e.g., Shaham et al., 2000). The likely explanation for these observations is that opioids raise levels of cortisol, a hormone that plays a primary role in stress responses; and cortisol, in turn, raises the level of activity in the mesolimbic reward system (Kreek and Koob, 1998). By these mechanisms, stress may contribute to the abuser's desire to take drugs in the first place and to his or her subsequent compulsion to keep taking them.

PHARMACOLOGICAL INTERVENTIONS AND TREATMENT IMPLICATIONS

In summary, the various biological models of drug addiction are complementary and broadly applicable to chemical addictions. Long-term pharmacotherapies for opioid dependence and addiction counteract or reverse the abnormalities underlying those conditions, thereby enhancing programs of psychological rehabilitation. Short-term treatments for relieving withdrawal symptoms and increasing abstinence are beyond the scope of this article; instead, we refer readers elsewhere for detailed neurobiological explanations of the various nonopioid-based abstinence initiation approaches such as clonidine and clonidine-naltrexone for rapid detoxification (see O'Connor and Kosten, 1998, and O'Connor et al., 1997).

The medications most commonly used to treat opioid abuse attach to the brain cells' mu opioid receptors, like the addictive opioids themselves. Methadone and LAAM stimulate the cells much as the illicit opioids do, but they have different effects because of their different durations of action. Naltrexone and buprenorphine stimulate the cells in ways quite distinct from the addictive opioids. Each medication can play a role in comprehensive treatment for opioid addiction.

Methadone

Methadone is a long-acting opioid medication. Unlike morphine, heroin, oxycodone, and other addictive opioids that remain in the brain and body for only a short time, methadone has effects that last for days. Methadone causes dependence, but—because of its steadier influence on the mu opioid receptors—it produces minimal tolerance and alleviates craving and compulsive drug use. In addition, methadone therapy tends to normalize many aspects of the hormonal disruptions found in addicted individuals (Kling et al., 2000; Kreek, 2000; Schluger et al., 2001). For example, it moderates the exaggerated cortisol stress response (discussed above) that increases the danger of relapse in stressful situations.

Methadone treatment reduces relapse rates, facilitates behavioral therapy, and enables patients to concentrate on life tasks such as maintaining relationships and holding jobs. Pioneering studies by Dole, Nyswander, and Kreek in 1964 to 1966 established methadone's efficacy (Dole et al., 1966). As a Drug Enforcement Administration schedule II controlled substance, the medication is administered primarily in federally regulated methadone programs, where careful monitoring of patients' urine and regular drug counseling are critical components of rehabilitation. Patients are generally started on a daily dose of 20 mg to 30 mg, with increases of 5 mg to 10 mg until a dose of 60 mg to 100 mg per day is achieved. The higher doses produce full suppression of opioid craving and, consequently, opioid-free urine tests (Judd et al., 1998). Patients generally stay on methadone for 6 months to 3 years, some much longer. Relapse is common among patients who discontinue methadone after only 2 years or less, and many patients have benefited from lifelong methadone maintenance.

LAAM

A longer acting derivative of methadone, LAAM can be given three times per week. Recent concerns about heart rhythm problems (specifically, prolonged QT interval) have limited LAAM's use (U.S. Food and Drug Administration, 2001). Nevertheless, long-term maintenance on moderate to high doses of LAAM

can, like methadone maintenance, normalize physiological functions such as the cortisol stress response (Kling et al., 2000; Kreek, 1992, 2000; Schluger et al., 2001). Dosing with LAAM is highly individualized, and three-times-weekly doses range from 40 mg to 140 mg.

Naltrexone

Naltrexone is used to help patients avoid relapse after they have been detoxified from opioid dependence. Its main therapeutic action is to monopolize mu opioid receptors in the brain so that addictive opioids cannot link up with them and stimulate the brain's reward system. Naltrexone clings to the mu opioid receptors 100 times more strongly than opioids do, but it does not promote the brain processes that produce feelings of pleasure (Kosten and Kleber, 1984). An individual who is adequately dosed with naltrexone does not obtain any pleasure from addictive opioids and is less motivated to use them.

Before naltrexone treatment is started, patients must be fully detoxified from all opioids, including methadone and other treatment medications; otherwise, they will be at risk for severe withdrawal. Naltrexone is given at 50 mg per day or up to 200 mg twice weekly. Patients' liver function should be tested before treatment starts, as heroin abusers may have experienced elevation of certain liver enzymes (transaminases) caused by infectious complications of intravenous drug use, such as hepatitis (Verebey and Mule, 1986).

Unfortunately, medication compliance is a critical problem with naltrexone, because unlike methadone or LAAM, naltrexone does not itself produce pleasurable feelings. Poor compliance limits naltrexone's utility to only about 15 percent of heroin addicts (Kosten and Kleber, 1984).

Naltrexone is also sometimes used to rapidly detoxify patients from opioid dependence. In this situation, while naltrexone keeps the addictive opioid molecules away from the mu opioid receptors, clonidine may help to suppress the excessive NA output that is a primary cause of withdrawal (Kosten, 1990).

Buprenorphine

Buprenorphine's action on the mu opioid receptors elicits two different therapeutic responses within the brain cells, depending on the dose. At low doses buprenorphine has effects like methadone, but at high doses it behaves like naltrexone, blocking the receptors so strongly that it can precipitate withdrawal in highly dependent patients (that is, those maintained on more than 40 mg methadone daily).

Buprenorphine is expected to be approved by the Food and Drug Administration for the treatment of opioid dependence in 2002. Several clinical trials have shown that when used in a comprehensive treatment program with psychotherapy, buprenorphine is as effective as methadone, except for patients with heroin addiction so severe they would require a dose of more than 100 mg daily (Kosten et al., 1993; Oliveto et al., 1999; Schottenfeld et al., 1997). Buprenorphine offers a safety advantage over methadone and LAAM, since high doses precipitate withdrawal rather than the suppression of consciousness and respiration seen in overdoses of methadone, LAAM, and the addictive opioids. Buprenorphine can be given three times per week. Because of its safety and convenient dosing, it may be useful for treating opioid addiction in primary care settings, which is especially helpful since most opioid addicts have significant medical problems (for example, hepatitis B or C and HIV infection). Buprenorphine will be available in 4 mg and 8 mg tablets. A combination tablet with naloxone (Suboxone) has been developed to negate the reward a user would feel if he or she were to illegally divert and inject the medication. The maintenance dose of the combination tablet can be up to 24 mg and used for every-other-day dosing.

As office-based treatment of heroin addiction becomes available, the highest possible safety level (that is, minimal side effects) should be balanced with treatment effectiveness. The patient taking methadone must either visit the medical office daily (not feasible in most cases) or be responsible for taking daily doses at home, as scheduled. Accordingly, for an opioid-dependent patient who cannot be relied upon to take the medication as instructed and thus might overdose, buprenorphine in three doses weekly would be a safer choice than methadone. The patient's office visits could be limited to once or twice per week, with remaining buprenorphine doses taken at home. Also, buprenorphine has less overdose potential than methadone, since it blocks other opioids and even itself as the dosage increases.

SUMMARY

Opioid dependence and addiction are most appropriately understood as chronic medical disorders, like hypertension, schizophrenia, and diabetes. As with those other diseases, a cure for drug addiction is unlikely,

and frequent recurrences can be expected; but long-term treatment can limit the disease's adverse effects and improve the patient's day-to-day functioning.

The mesolimbic reward system appears to be central to the development of the direct clinical consequences of chronic opioid abuse, including tolerance, dependence, and addiction. Other brain areas and neurochemicals, including cortisol, also are relevant to dependence and relapse. Pharmacological interventions for opioid addiction are highly effective; however, given the complex biological, psychological, and social aspects of the disease, they must be accompanied by appropriate psychosocial treatments. Clinician awareness of the neurobiological basis of opioid dependence, and information-sharing with patients, can provide insight into patient behaviors and problems and clarify the rationale for treatment methods and goals.

ACKNOWLEDGMENT

This work was supported by NIDA grants number P50-DA-1-2762, K05-DA-0-0454, K12-DA-0-0167, R01-DA-1-3672, and R01-DA-1-4039.

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"" Response: The Neurobiological Model in Community Treatment Programs

Tom Brewster, L.C.S.W., Chris Farentinos, M.D., and Douglas Ziedonis, M.D.

Chris Farentinos: This is very important information for patients and counselors to have. Patients can understand their reactions in terms of, 'By taking this drug I stimulated my brain so much I've kind of extinguished its ability to produce certain neurotransmitters, and once I stop taking the drug, dysphoria will arise and that creates a cycle of addiction.' And the counselor can have more empathy for the client: It's not that the clients are not trying to get better or that they are bad people, but they feel so bad after they stop using the drug that they have to go back. There is also a neurobiological connection to impulsivity and personality disorders, so the whole thing fits together.

Doug Ziedonis: From a pragmatic point of view, this kind of article is useful for stigma-busting with legislatures, since they don't want to pay for habits or choices. They want to pay only in cases of medical necessity.

The recovery community agrees with the disease concept of addiction. Most of the recovery models people use when working with addicted patients use some type of bio-psycho-social-spiritual matrix. The biological part is considered most important in early stages of recovery, maybe during the first year, because the patient has to deal with acute withdrawal, dependence, and then protracted withdrawal.

Where the recovery and medical communities often don't see eye to eye is when the disease concept gets translated into a rationale for using medication, whether it is in the case of dual-diagnosis patients or even the use of naltrexone to treat opiate addiction. Naltrexone is a great medication; it can be very useful in treating impaired professionals. But if you survey average community treatment programs, hardly any patients are on naltrexone. Methadone is its own medical model system that doesn't always link well with places that use the abstinence model. I have worked at abstinence programs and have worked at Yale as medical director of a methadone program. I favor the use of methadone as part of a treatment continuum.

Tom Brewster: Therapeutic communities have long been the most resistant single group to the use of medications for opiate abuse treatment. I think there has been a movement among providers to utilize methadone more in our therapeutic communities. There certainly has been in my community. We actively maintain patients on the medication and have trained our counselors. Our recovering counselors are abstinence-oriented individuals: they don't drink and they certainly aren't using illicit substances. They generally challenge any form of medication, particularly analgesic medication, even when it should be legitimately used for pain reduction after surgery and so forth. But our program has embraced methadone despite this resistance, because of the biological connection described by Kosten and George.

The information about biology and about medications is useful for patients who are asking to be taken off methadone. Patients come to me and say, 'I want to detox. Methadone is not good. It is a weakness. My wife wants me off of it, my employer wants me off, society wants me off, my probation officer wants me off.' Corrections workers press patients to feel guilty about taking a narcotic medicine. They don't believe in it. We resist this pressure because we know better. The relapse rate of those who get off methadone maintenance is perilously high. We strongly discourage people from going off the medicine. &

Treatment Practice and Research Issues in Improving Opioid Treatment Outcomes

Providers of treatment for opioid addiction have entered a new era of accountability, as Federal and State regulators increasingly demand objective evidence of treatment effectiveness. Since the length of treatment is associated with success of treatment, opioid treatment programs that demonstrate an ability to retain patients can make a strong case that they are effective. The challenge to opioid treatment providers is to examine their practices and begin organizational change to incorporate scientifically proven practices to improve patient retention. The challenge to the research community is to partner more effectively with community-based providers to help them through the transition.

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May 18, 2001, was a landmark day in the history of what was once called methadone maintenance treatment (MMT) or, more recently, opiate substitution (or replacement) treatment. On that date, Federal oversight of MMT shifted from the Food and Drug Administration, the Federal regulating authority since 1972, to the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) (DHHS, 2001). The main objective of the change in oversight is to move programs toward stricter accountability for patient outcomes, such as decreased drug use, reduced criminal behavior, and improved social functioning. Increasingly, programs will need to do more to maintain their licenses than simply adhere to the regulations governing the delivery of methadone, LAAM, and other medications for treating opioid addiction. They also will have to demonstrate that they measure and meet criteria for acceptable levels of treatment effectiveness and patient benefit.

The new rules also give providers more flexibility to adopt scientifically validated outcome-enhancing practices. To reflect the emphasis on a variety of potentially effective practices that go beyond methadone maintenance, SAMHSA has instituted the label "opioid treatment program" (OTP).

This article offers an OTP director's perspective on how programs can succeed in the new era. OTPs must draw on scientific research, which has provided a wealth of studies to inform clinical practice. A key principle that has emerged is that the length of time a patient stays in treatment ("retention") is a highly significant indicator of program quality; measured repeatedly, it is a tool for assessing progress in improving outcomes.

To achieve and document greater patient retention as well as other desirable patient outcomes, many OTPs will need to make sometimes far-reaching changes in their operations and offerings. Collaboration between providers and researchers will be essential to solving the many practical problems OTPs must overcome to fully implement science-based treatments.

PATIENT RETENTION: WHAT RESEARCH SHOWS

There is clear and abundant evidence that longer duration of treatment is associated with better patient outcomes (see Figure 1), both during methadone maintenance and after successful completion of treatment (that is, gradual tapering from methadone with psychosocial stability and no return to opioid addiction) (Ward et al., 1998). The studies suggest that treatment should last no less than 1 year, and that 2 or 3 years of treatment produces superior outcomes. No studies support setting a fixed limit on duration of treatment. Thus, patient retention is a key performance indicator for OTPs to routinely measure and evaluate, and taking steps to increase patient retention is a potentially valuable strategy for improving patient outcomes.

Researchers have studied a number of patient-related and program-related factors to see whether they affect retention of patients in treatment. Patient-related factors include age, race, ethnicity, sex, the number of substances abused, psychopathology, employment, social support network, and level of motivation to quit drugs. Findings about which of these factors affect retention have been mixed; but even if there were clear findings, they would be of little practical help to providers seeking to improve retention and outcomes. For both practical and ethical reasons, OTPs cannot select for admission only those applicants whose characteristics indicate a higher probability of success in treatment.

OTPs, then, must look to program-related factors for opportunities to make changes that will improve their patients' outcomes. Among the factors that can enhance success, according to studies, are:

- Use of individually determined methadone doses and higher doses (≥60 mg) (Maddux et al., 1997);
- Individualized treatment plans that identify needs for employment, family, legal, financial, and other supplemental services (Joe et al., 1991) and access to such services (Condelli, 1993);
- Use of contingency contracting with negative incentives (for example, treatment sanctions; Saxon et al., 1996) or positive incentives (such as medication take-home privileges; Chutuape et al., 1999) linked to urinalysis results and attendance at dosing and counseling sessions;
- Counselor behaviors and ability to form a working alliance with patients (Blaney and Craig, 1999);
- Staff acceptance of the philosophy of maintenance treatment, which sees opioid addiction as a medical illness that requires medication and counseling for an indefinite period (Caplehorn et al., 1998);
- Frequency of counseling contacts and other program features (Magura et al., 1999); and
- Greater experience and involvement with treatment on the part of the OTP director (Magura et al., 1999).

IMPLEMENTING NEW PRACTICES: OBJECTIVES AND BARRIERS

Key research-proven objectives that OTPs can adopt to improve patient retention and other outcomes include acquiring research information; identifying cost-effective research-based interventions; securing high-quality social services; and tracking retention rates. As they pursue these objectives, OTPs will encounter practical barriers in the areas of resources and staffing. They will also face information gaps where research to date has not provided key answers and where implementation-oriented research will be critical to an efficient transition to more effective treatment.

Learning to acquire, evaluate, and use research will be a necessary first task for many OTPs. In this author's experience, OTP managers and their staffs are largely unaware of specific research findings on the relationship of treatment variables to retention and outcomes. As knowledge is an important element of change, the research community and leaders in OTP associations could do a better job of disseminating findings to the treatment community. CSAT's Treatment Improvement Protocol (TIP) series, NIDA's "Blending Research and Practice" meetings, this new NIDA journal, and the training efforts of the national network of Addiction Technology Transfer Centers (ATTCs) are examples of a good start in that direction. However,

FIGURE 1. Time in Treatment and Daily Opioid Use in Year Following Discharge

Duration of treatment is a key measure for assessing the quality of a treatment program because it is directly related to successful outcomes. In a study with 3,248 patients, daily opioid use in the year following discharge from treatment declined in direct proportion to the length of time patients stayed in treatment, regardless of the treatment modality—therapeutic community, outpatient drug-free, or methadone maintenance. Patients who simply underwent detox without followup treatment had the poorest outcomes. Decreased criminal behavior showed a similar direct relationship to length of treatment.

Source: Simpson and Sells, 1982.

many programs do not take advantage of those resources. Furthermore, OTP managers who do inform themselves must also facilitate knowledge dissemination to their staffs.

Having reviewed the literature linking program characteristics to retention, an OTP manager may be able to identify several ways to modify or enhance a program to improve outcomes. At this juncture, an important objective will be to select for implementation those that use the OTP's resources cost-effectively—in other words, that are worth the investment. This decision can be difficult, in part because researchers have tended to test interventions without sufficient attention to the resource limitations of OTPs. For example, one research project found that a take-home incentive program—granting take-home privileges to patients who reduce their drug use—had a positive effect on outcomes (Chutuape, 1999); however, the resources devoted to the study were greater than most OTPs enjoy. No estimate was made of how much an agency might need to spend to implement and sustain a take-home incentive program, or whether such a program might yield a better return on the investment of agency resources than, say, training and supervising counselors to be more proficient in the use of motivational interviewing. More research focus on the cost-effectiveness of various interventions or staff training strategies would be extremely valuable.

Once an OTP director has selected a science-based intervention or program component for implementation, staff training will be critical for success. This is another area, however, in which research has not yet provided OTP managers with much guidance. If, for example, an OTP manager, recognizing the counselor's important role in improving patient retention, wished to improve staff skills in the use of motivational interviewing, how would that best be accomplished? What kind of training, delivered by a trainer with what qualifications, would yield the highest probability of skills acquisition and incorporation of those skills in clinical practice? Scientific research to help managers resolve some of these questions would be very welcome.

Scientific research has shown that outcomes improve when individualized treatment plans match service delivery to individual patients' needs and appropriate high-quality social services are provided. In attempting to meet this objective, OTPs will again confront issues of developing and allocating resources and effecting organizational change.

With resources limited by low reimbursement rates, many OTPs look to their communities for quality health and social services for their patients. Unfortunately, many communities and social service providers view OTPs and their patients with antipathy or disdain. Often, they misunderstand opiate agonist therapy, consider OTPs little more than legalized drug dealers, and consequently want nothing to do with an agency or its patients. In addition, many social service providers seem to view heroin addiction as

an intractable condition brought on by willful misconduct and so reject or give lowest priority to patients referred by OTPs. The research community has in recent years publicized the effectiveness of opioid addiction therapy, encouraging the public to correctly characterize opioid addiction as a chronic medical disorder. In some areas this activity has led to significantly better acceptance of OTPs and their patients. Sadly, much work remains.

To evaluate its strategy for improving outcomes and to set goals for continuing improvement, an OTP must measure patient retention and monitor how it changes over time. Many OTPs cannot currently accomplish such measurements and will need to redesign their patient data systems to obtain and record all the necessary information on patient characteristics as well as the type and amount of treatment delivered to each. Many OTPs also will want to convert to a computerized patient information system to be able to analyze information easily and quickly. These are daunting organizational tasks that entail significant costs—both financial resources and staff time. Some State governments assist OTPs in their data acquisition and analysis, others do not. The research community could make an invaluable contribution by equipping agency and statewide data systems with the ability to perform survival analysis, the key statistical technique for measuring and comparing rates of retention (Magura et al., 1998).

Two other practical issues face OTPs preparing for programmatic change: lack of implementation manuals and lack of expertise in organizational change. The shortage of practical implementation manuals—for example, guidance for how to start up and run a take-home incentives program, including quality assurance guidelines—is a barrier to change but one the research community could address by ensuring creation and dissemination of such documents once an intervention has been validated in studies. Development of such materials should be one of the requirements for funding of research studies.

OTP managers have a wide range of experience and expertise and now face a sea change in expectations for the operation of their programs. Many could benefit from guidance on effective ways to prepare for and implement organizational change.[1] For 30 years, OTPs have struggled to comply with multitudinous regulations and local laws (such as limits on dose levels, length of treatment, and take-home privileges), clinical practice constraints (for example, limited counseling sessions per patient per month), as well as internal policies and procedures growing out of the philosophies of administration and staff. This history has ingrained attitudes and responses among program managers and staffs that will require special effort to change. OTPs and their staffs—much like the patients they treat—approach the change process with different strengths and challenges (D'Aunno et al., 1999).

ADMINISTRATIVE DISCHARGE: TROUBLING ISSUES

As an OTP director, this writer could improve his agency's retention rate with the stroke of a pen, by eliminating the possibility of administrative discharge (expulsion for cause) from treatment. Administrative discharge clearly lowers retention rates, but just as clearly is necessary in some cases. Moreover, while research and improved treatments may be able to provide standards for some types and causes of administrative discharge, others seem likely to remain matters of difficult—and ethically troubling—judgment.

A key principle is that the length of time a patient stays in treatment is a highly significant indicator of program quality.

Unremitting cocaine use by patients in OTPs is one of the most common causes of administrative discharge as well as dropout from treatment (Magura et al., 1998). Developing specialized, cost-effective therapies for cocaine-using methadone patients would help improve retention.

The most difficult administrative discharge decisions involve lack of response to treatment. While program rules often cite noncompliance rather than nonresponse as the reason for discharge, in effect they define what the program deems to be nonresponse. In an ideal world, there would be no need for such rules. OTPs would have the resources to take all who sought treatment and let patients continue indefinitely as long as they participated, even minimally, and did not impede the recovery of others. As things stand, however, with limited public funding and statutory caps on treatment "slots," an OTP manager must weigh keeping a poorly responding patient in treatment against providing treatment access to someone else who might be able to benefit more from what the program offers.

In this environment, science can help clinicians make more informed decisions about who should stay and who should go. Currently, agency managers and the staff determine what constitutes nonresponse sub-

jectively, from their clinical perspectives. OTPs would benefit enormously if research could provide ways to make these decisions objectively, by identifying signs—for example, levels of continuing drug use, absences from dosing and counseling sessions, lack of progress toward treatment goals—that continuing treatment will probably be fruitless. Such data would also help OTPs advocate for increased funding and treatment options, such as low-threshold treatment programs that provide options other than expulsion for lack of response. Research could also help OTPs by investigating how the presence of nonresponders affects the therapeutic environment for other patients—another concern that managers weigh when considering administrative discharges.

Learning to acquire, evaluate, and use research will be a necessary first task for many OTPs.

Clearly, for programs to be viable, some limits for acceptable behavior must be set and enforced. However, whether a particular behavior is unacceptable can be difficult to judge. OTPs generally concur that behaviors that threaten the safety of patients and staff and the status of the program in the community warrant expulsion, and they agree that violence or threats of violence against patients (on agency premises) or staff (on or off agency premises) and drug dealing fall into this category. Yet whether a particular act constitutes threatening behavior or drug dealing can be debatable. It is hard to imagine science lending any guidance to these judgments.

RECOMMENDATIONS TO CLINICAL COLLEAGUES

We stand at the threshold of a new era in the treatment of opioid addiction. Not only is methadone treatment changing, but new medications will soon be available for deployment in a variety of ways, not just in traditional clinic-based settings. We will be more accountable for outcomes than ever before. Patients, their families, our communities, and funding agencies will ask not whether opioid treatment is effective, but how well our patients do. Some of us will rise to the challenges of the new era and thrive; some won't. In this writer's opinion, three steps are critical:

- **Embrace change.** We have to change both our thinking and our practices, beginning with a conversation between managers and staffs. Agency administrators will need to understand the new environment and engage their staffs in a dialogue about the reasons to change and methods of change and then explore together the perceived benefits and barriers to change. This means, in short, taking a fearless inventory of the strength and weaknesses of each agency.

  In my own case, the inventory of my agency's practices and assets revealed that our intake assessment form, developed some years earlier, was not going to be adequate. We switched to the Addiction Severity Index (ASI), a standardized assessment instrument (available free at *www.tresearch.org /Assessment%20Inst/instruments.htm)* that allows us to measure our retention rates and compare them to our past performance and to other programs using the ASI. The ASI also facilitates initial treatment plans that focus on patients' needs for services in a variety of life domains, not just their drug addiction.

- **Focus on data.** Read the literature about program factors that affect retention and outcome, and examine your agency practices in that light. Decide what data you need to collect for the ongoing program evaluation and quality assurance necessary to improve outcomes. Take the necessary steps to collect those data into a computerized database. Commit to a serious, ongoing allocation of agency resources for staff training and supervision.

  In our agency, we have trained our intake counselors to gather the ASI information on all incoming patients and enter it in an electronic database that I then use in continuous program evaluation to examine patient characteristics, including their service needs, how those characteristics and needs change over time, and response to services. The cost to my agency was for staff training and acquisition of computers and the ASI software.

- **Partner with researchers.** Reach out to the research community for help with decisionmaking on data acquisition and for ongoing data analysis. The collaboration will help you to better define and answer questions about how you can improve outcomes for your patients. All of us learned most, if not all, of what we know about clinical practices from listening to our patients. Think of program evaluation as a more systematic way of listening to your patients.

  Through partnering with research colleagues to conduct studies at my agency, our staff has learned more about what kinds of behavioral interven-

tions work with our patients, and clinical personnel are better able to apply those interventions. Participation in research has brought financial assets to my agency and allowed us to attract and retain very capable clinicians.

RECOMMENDATIONS TO RESEARCH COLLEAGUES

The new emphasis on program evaluation and quality assurance in OTPs affords a rare opportunity for collaboration between clinical practitioners and researchers interested in treatment improvement. This is the era when research-to-practice can really deliver on its heretofore unrealized promise. What is the research community to do to help make this happen? Here are four steps to accomplishing that goal:

- **Stop doing independent studies on the effectiveness of methadone treatment.** If the new CSAT regulations work as designed, this country will have hundreds of OTPs systematically gathering data and evaluating their programs' clinical outcomes. Partner with OTPs to design and conduct collaborative studies to refine the analysis of the treatment factors that we know contribute to retention and patient outcome and to identify additional treatment variables that affect outcomes. The power of the data being collected by OTPs will also allow analysis of gender-specific treatment variables that affect retention and outcomes.

- **Study cost-effectiveness.** While studies have shown mixed results with respect to the amount of variance in patient outcomes attributable to program variables, OTPs want and need to know which program variables offer the best return on investment to improve outcomes. For example, given its financial constraints, should a program devote funds to more frequent urinalyses and incorporation of results in treatment planning, or should it spend that money on developing counselor competencies?

- **Develop implementation and quality assurance manuals.** Using your experience as study designers and implementers, generate manuals to guide OTPs through the process of implementing state-of-the-art clinical interventions and practical self-evaluation protocols.

- **Develop "best practice" benchmarks for patient retention and outcomes.** Help OTPs, their regulators, and funders understand what optimal clinical performance looks like so that they might measure program performance against those standards. This will require refining and applying the techniques, called case-mix adjustment, used in performance comparisons to make allowance for the fact that populations in some programs are more difficult to treat than others. Comparisons of outcomes made without taking into account the relative difficulties of treatment populations can lead to erroneous conclusions and unwarranted reactions, such as personnel actions or program funding cuts or decertification.

NOTE

[1] Readers interested in a guidebook for organizational change in addiction treatment programs could refer to *The Change Book: A Blueprint for Technology Transfer,* produced and distributed by the National ATTC, which can be reached at 1-877-652-2882 or *www.nattc.org.*

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RESPONSE: THE NEW ENVIRONMENT OF ACCOUNTABILITY FOR OTPs

R. Lorraine Collins, Ph.D., William Cornely, M.H.S., and Christine Grella, Ph.D.

When researchers work with treatment providers, our methods have to be objective, but we also want the treatment to be successful, and partnership is important for that reason.

Lorraine Collins: The demand for accountability is ratcheting up. Methadone programs may find themselves having to be increasingly accountable.

William Cornely: With respect to retention of patients in opioid treatment, most drug-free programs have already made the transition to viewing the patient as a customer who must be retained, and their experience may be helpful to methadone programs.

What other outcomes, besides retention, should be considered for accountability? For example, what about having someone off methadone in a year or 2 years, or having lower incidence of AIDS?

Christine Grella: Ideally, methadone programs would target a range of outcomes, including use of opioids and other drugs, alcohol use, and then issues such as housing, unemployment, and general psychosocial functioning. A troubling issue that I saw first-hand while working on a study in a methadone clinic is that much of the patients' ability to respond to treatment was related to issues in their communities and to things like whether they continued to live with a substance abuser. These environmental issues are a huge determinant of outcomes and completely beyond our control.

Grella: Jackson's call for partnership—informing the treatment staff of current research and inviting researchers to work with providers in testing different approaches to improving delivery of treatment—is excellent. He is absolutely right, too, in saying we need more research on how organizations can change to implement different treatment practices. A potential research question would be, 'What program characteristics are associated with the ability to implement effective practices?' Jackson cites one example: a study showing that attitudes and experiences of program directors in methadone programs made a difference.

Collins: Many programs have staff members who work there because of their experiences recovering from substance abuse and who have an understandable bias toward whatever treatment regimen was successful for

them. Those perspectives are now being challenged or questioned by the emphasis on accountability. In the future, treatment personnel may have to come from other backgrounds, with professional rather than experiential training. Research might look at the question, 'How well are staff members with each kind of background able to perform as drug abuse treatment providers?'

Grella: I was intrigued with the author's suggestion that the research community can give more guidance on different ways to train the program staff. I think this is especially important in OTP facilities where the staff—especially those who have worked a long time—may have strong beliefs about how effective the treatment is and what they can accomplish with the patients they see. We really need to test different approaches to working with staff members to upgrade their skills and deal with their resistance to change.

Collins: The use of treatment manuals and other materials to disseminate actual treatment protocols is going to be crucial for raising the level of staff knowledge. The large multisite research studies are already starting to do this. The manuals walk practitioners through the study protocols step by step. For example, here is a new assessment instrument, here is how you score it, here are some ways of intervening with patients with each possible score.

To some extent, I think Jackson sees researchers as able to do more than we actually can. Researchers will not be able to influence all the State regulations and policies that affect credentialing. With respect to salary structures, we will not be able to do much beyond saying that with better education and better pay, you might have a more effective staff. As to the issue of enhancing the ability of agencies to perform survival analysis, even universities have difficulty finding staff to do survival analysis.

Grella: When researchers work with treatment providers, our methods have to be objective, but we also want the treatment to be successful, and partnership is important for that reason.

Cornely: This issue of noncompliant—for lack of a better word—patients is one that programs grapple with all the time. When you have to make a decision about keeping someone in treatment who continues to use drugs, especially in drug-free treatment, you walk a fine line between maintaining the integrity of the program and helping the individual. In our program we will usually retain a patient who uses drugs and help them get through the relapse, intensify services, and those sorts of things. Some other programs are very rigid: If you use, you are kicked out.

Generally, the belief is that good treatment means increasing treatment, rather than withdrawing it, when patients continue to use or relapse. Jackson suggests that a wider range of treatment options might be the answer for some nonresponding individuals. We can certainly design a study where we have different levels of intensity—high, enhanced, etc. But given the reality in which these programs function, with their limited resources, how are they going to implement the programs?

Ideally, methadone programs would target a range of outcomes, including issues such as housing, unemployment, and general psychosocial functioning.

Grella: The research is very clear that individuals in methadone therapy who use cocaine or alcohol have relatively poor response to treatment. We can design studies to look at cocaine-reduction protocols in methadone programs, but the degree to which community OTPs can implement them is going to vary widely. We keep coming back to the issues of resources and feasibility.

Collins: A lot of programs aren't focusing enough on mental health issues as they relate to substance abuse. Maybe someone is not responding well to methadone because of other psychiatric problems that are not being addressed by the program. We probably need broader assessments. Research can definitely help with that. One research-based model is [Prochaska and Di Clemente's] 'Stages of Change,' which has been applied to drug abuse. Stages of Change looks at where people are along a continuum that goes from precontemplation [not really considering the life changes that treatment will require], through contemplation [of committing to the changes], to action, and so on. If somebody is in the precontemplation stage, it's not the right time to jump into treatment, but there might be some other activities he or she could engage in to move the process along. &

Special Communications

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Implications of Methadone Maintenance for Theories of Narcotic Addiction

Vincent P. Dole, MD

Clinical success in rehabilitation of heroin addicts with maintenance treatment requires stability of the blood level in a pharmacologically effective range (optimally, 150 to 600 ng/mL)—a phenomenon that emphasizes the central importance of narcotic receptor occupation. It is postulated that the high rate of relapse of addicts after detoxification from heroin use is due to persistent derangement of the endogenous ligand-narcotic receptor system and that methadone in an adequate daily dose compensates for this defect. Some patients with long histories of heroin use and subsequent rehabilitation on a maintenance program do well when the treatment is terminated. The majority, unfortunately, experience a return of symptoms after maintenance is stopped. The treatment, therefore, is corrective but not curative for severely addicted persons. A major challenge for future research is to identify the specific defect in receptor function and to repair it. Meanwhile, methadone maintenance provides a safe and effective way to normalize the function of otherwise intractable narcotic addicts.

(*JAMA* 1988;260:3025-3029)

THE ACHIEVEMENTS of molecular biology in analyzing processes of cell function suggest that all diseases, including disorders of behavior, might ultimately be reduced to biochemical terms. The claim is extreme, but at least for narcotic addiction the optimism seems to be justified. Analysis of the clinical results of methadone maintenance treatment during the past 25 years, coupled with advances in the understanding of narcotic receptors and their ligands, supports the view that compulsive use of narcotics stems from receptor dysfunction.

This is a departure from the traditional concept of addiction as misbehavior—a distinction of great practical consequence. As recently as four months ago the Supreme Court affirmed the denial of veteran's benefits to alcoholics on the ground that their condition is due to "willfull misconduct,"[1] an opinion that seems to be at odds with the medical tradition of basing services on need rather than on fault. The ruling made explicit the widespread prejudice against addicts, one that if carried to logical limits would deny treatment to a skier with a broken leg or a sunbather with skin cancer. For the immediate future, the harshness of the ruling has stimulated corrective action in the legislature. In the longer term, scientific understanding should displace prejudice, and attitudes toward addictive behavior should become more consistent with medical tradition. At least so one may hope, provided that the scientific community can provide a basis for rational understanding of addictions as diseases.

From The Rockefeller University Hospital, New York.

Based on a lecture given at the presentation of the Albert Lasker Clinical Medicine Research Award, New York, Nov 18, 1988.

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METHADONE NORMALIZES FUNCTION

This article, updating previous analyses,[2,3] is concerned mainly with the theoretical implications of methadone maintenance treatment and the direction of future work. The practical success of maintenance in rehabilitation of tens of thousands of addicts, now especially important as a means of limiting the spread of acquired immunodeficiency syndrome, has been documented[4-6] and need not be reviewed further. The issue to be considered here is the basis of this success. The treatment is corrective, normalizing neurological and endocrinologic processes in patients whose endogenous ligand-receptor function has been deranged by long-term use of powerful narcotic drugs. Why some persons who are exposed to narcotics are more susceptible than others to this derangement and whether long-term addicts can recover normal function without maintenance therapy are questions for the future. At present, the most that can be said is that there seems to be a specific neurological basis for the compulsive use of heroin by addicts and that methadone taken in optimal doses can correct the disorder. When somatic function has been normalized, the ex-addict, supported by counseling and social services, can begin the long process of social rehabilitation.

The social rehabilitation of methadone maintenance patients and the normalization of endocrine function[7] substantially exceed the expectation that Marie Nyswander, MD, and I brought to the problem 25 years ago. Then, as

now, it was clear that narcotic addiction could not be eliminated simply by prohibition, however severe the penalties. For a chronic user, the need for narcotic is inelastic. With tens of thousands of such persons as a market, limiting supply without reducing demand increases the price of illicit drugs to the point that black marketers are willing to take the necessary risks. The net result is a highly profitable business for the drug sellers, corruption of government officials, infiltration of legitimate business with laundered money, increase in crime committed by addicts to support their expensive habits, filling of jails, and deaths from injection of contaminated drugs of uncertain potency. The clear lesson to be learned from repeated failures of past policy is that demand must be reduced by effective treatment. The epidemic of narcotic use has not been extinguished by prohibition, civil commitment, jailing, or other punishments.

On the other hand, it must be conceded that attempts to treat addicts with narcotic maintenance 70 years ago were not successful. Indeed, leaders in the medical profession and the Public Health Service cooperated with enforcement agents in closing the experimental clinics, thus effectively transferring responsibility for control of addiction to the police.[8] When Marie Nyswander and I began our work, the position of the Federal Bureau of Narcotics was that maintenance had been tried and had failed. The argument could not be denied, but it seemed self-serving. The failure of clinics that had been organized hastily in response to the panic that followed enactment of the Harrison Narcotic Act constituted the database. Not only were physicians ill prepared to deal with the flood of desperate addicts, they had only two narcotic drugs, morphine and heroin, to prescribe.[8] In retrospect, a major reason for their failure is clear: the physicians were using the wrong drugs.

Our objective at the onset was simply to find a medication that would keep addicts content without causing medical harm and that would be safe and effective for use over long periods in relatively stable doses. The goal of social rehabilitation of addicts was not part of the original plan. Merely satisfying addicts, although not an ideal result, seemed better than the existing policy that forced incurable addicts into criminal activity.

STABILITY ESSENTIAL

The initial studies, conducted at Rockefeller Hospital (New York) in collaboration with Mary Jeanne Kreek, [illegible] of different narcotic drugs when given in various doses to long-term users of heroin. All drugs were of the opiate class—that is, they were known to exhibit cross-tolerance with morphine—and all had been approved for human use as analgesics. The reason for failure of previous attempts to maintain addicts on morphine soon became apparent: the patients could not be stabilized on the drug. Despite frequent injections, their condition fluctuated between somnolence and agitation throughout each day, with tolerance increasing over consecutive days to the point that they were almost continuously agitated even when receiving huge doses of morphine. Similar results were obtained with heroin (which is essentially the same drug as morphine since it is rapidly converted to morphine in the body), hydromorphone, codeine, oxycodone, and meperidine. The prospect for maintenance treatment did not look promising at this point.

A remarkably different result was seen when, in the course of the scheduled testing, methadone was administered. The fluctuation in clinical state became less and then disappeared. Doses became stable. The patients seemed normal. Most remarkably, their interests shifted from the usual obsessive preoccupation with timing and dose of narcotic to more ordinary topics.[9] We had no explanation for this surprising result. Prior to our studies, methadone had been tested at the Public Health Hospital (Lexington, Ky) and was found to be a typical opiate, distinguished from morphine only by greater oral effectiveness and a somewhat longer period of action.[10] However, because of the favorable response, we decided to continue administration of methadone beyond the original schedule and to observe longer-term effects. It was not until several years later that an explanation for the unusual result became apparent: the concentration of methadone in blood is stabilized by reversible absorption into tissues," mainly the liver.[10] The key factor is the reversibility of this absorption. Immediately after ingestion of the daily dose, 99% of the medication is bound to the tissues in equilibrium with the concentration in blood. It is released as the concentration falls, thus buffering the level. With a relatively steady concentration in blood, the narcotic receptors in critical cells remain continuously occupied and the patient becomes functionally normal. The essential feature in the treatment is the stability of receptor occupation, which permits interacting systems to function normally. The physiological and behavioral disturbances in heroin addiction apparently are consequences of the rapid changes in status of the endogenous narcotic [illegible]ceptor–ligand system. When the addict takes short-acting narcotics, the system cycles between abstinence and narcosis several times a day. A stable state of adaptation is impossible.

Our work involved a fortunate accident that explains why the unique value of methadone for maintenance had not been discovered previously. The patients had just completed a long series of tests with other opiates and, as a consequence, had developed a high tolerance to narcotics. Therefore, methadone was administered in exceptionally high doses, about ten times greater than is needed for analgesic action in naive patients. Injected in a single, small dose to a nontolerant patient, methadone is a relatively short-acting drug. The bulk of the dose is quickly removed from blood and later is returned to circulation at a pharmacologically insignificant level. Only when large doses of methadone have been administered repeatedly do the nonspecific binding sites come into equilibrium with a pharmacologically effective concentration in circulating blood. When this condition is reached, all that is needed for buffering the concentration at a high enough level to ensure significant occupation of receptors is a single daily dose to replace the amount of drug that has been eliminated by metabolism. Moreover, because of efficient absorption from the gastrointestinal tract, the dose can be given orally, thus eliminating needle use.

SPECIFICITY

Studies of the original six patients on our metabolic ward demonstrated the absence of acute narcotic effect in methadone maintenance patients and provided an understanding of the importance of receptor occupation. Switching the daily dose to *d*-methadone in place of the usual racemic mixture of *d*- and *l*-methadone was followed by the gradual appearance of abstinence symptoms, as expected from the fact that the narcotic activity of methadone is limited to the *l*-isomer. The patients, not noticing any difference in the taste or immediate effects of the daily dose, reported on the next day that they seemed to be "getting the flu." Only on the third day did they begin to suspect the medication and asked if "something had happened to the methadone." At this point they were returned to the usual racemic mixture. All symptoms cleared immediately. The patients had responded to the fall in concentration of *l*-methadone in blood and the resultant dissociation of this active isomer from critical re-

tors. When returned to medication containing *l*-methadone, they again became functionally normal.

The acute effect of naloxone, an antagonist that displaces narcotic ligands from receptors, shows the extreme sensitivity of physically dependent patients to the degree of occupancy of their narcotic receptors. Within a few seconds after an intravenous injection of a minute dose of naloxone (1/20 the amount that might be used in treating a nontolerant patient with narcotic overdose), a maintenance patient will be put into acute abstinence, with profound dysphoria. The subjective sensation apparently defies description in ordinary terms, being reported as a terrible feeling not like anything else. To an observer the patient appears to have been suddenly plunged into severe depression; he becomes immobile, sagging in posture, apparently grief-stricken.

Nontolerant patients are essentially unreactive to naloxone but are highly sensitive to narcotics. The classic studies of Houde et al,[9] quantitating the analgesia in pain patients following administration of a single dose of narcotic, showed a reproducible time course that depended on the dose and degree of tolerance induced by previous exposure. Subsequent studies by Berkowitz et al[10] correlated this effect with the blood level of morphine, thus demonstrating a direct, moment-to-moment relation between analgesia and occupation of narcotic receptors. Studies by Inturrisi et al[11] during the past 15 years have provided quantitative analyses of pain relief as a function of narcotic blood level. Clearly, the subjective experience of pain is inversely related to receptor occupation, given a constant input of sensory signals from injured tissue and dependent on the degree of narcotic tolerance.

PERSISTENT RECEPTOR DISORDER

An interpretation of these phenomena is that the narcotic receptor–ligand system acts as a modulator, adjusting the intensity of suffering and the body's hormonal response to stress. In nontolerant patients, the reactions to tissue damage and related stresses are modulated by the natural ligands, the opioid peptides, while pain can be abolished therapeutically for a limited time by a dose of narcotic drug. However, repeated injections of narcotic lead to down-regulation of the modulating system and possibly also to suppression of endogenous ligands, thus contributing to narcotic tolerance and dependence and progressively diminishing the analgesic sensitivity of narcotics.

This oversimplified analysis assumes a balance between activating and modulating processes. Under normal, unstimulated conditions, both processes are quiescent. When sensory stimuli activate neurological and humoral systems, the modulating processes react to protect against excessive response. With long-term administration of narcotics, the modulating system is down-regulated. The receptors become insensitive both to narcotic drugs and to their natural ligands. A new stability is achieved if methadone is given in an adequate daily dose, but at the price of continued dependence on the medication. Thus, a fundamental question in treatment of long-term users of narcotics is whether the modulating systems can return to normal function after termination of narcotic input. Ideally, methadone would be used as a stabilizing medication to provide immediate intervention, stopping the use of illicit narcotics and normalizing general metabolism. Later, after medical and social rehabilitation, the maintenance medicine would be withdrawn slowly and the patient would be totally cured.

Unfortunately, cure of chronic narcotic addiction is not that simple. Some patients do well after rehabilitation and termination of methadone maintenance, but the majority, although equally motivated, experience dysphoria, restlessness, irritability, and recurrent urges to use heroin again. The danger of relapse is great under these conditions. Objectively measurable physiological disturbances persist after detoxification from heroin or any other narcotic that has been used for a long time. These were noted by Himmelsbach[14] in early studies of the abstinence syndrome at the Public Health Hospital. Observing signs of dependence (sympathetic nervous system hyperactivity) that persisted up to two years in prisoners serving long sentences, he surmised that the almost invariable relapse of prisoners after release was "abetted by what seem to be indelible effects of addiction on the nervous system."[14]

It had, of course, long been known that most long-term users of narcotics relapse after withdrawal of the drug. The Public Health Hospital was started in 1935 under the reasonable assumption that medically assisted detoxification with counseling, general medical care, and healthful living on a Kentucky farm would provide optimal conditions for cure. Nevertheless, more than 90% relapsed after return to New York City.[15] Although the hospital made major scientific contributions, using volunteers from the population of prisoners to test the addictive potential of new drugs and conducting fundamental studies of narcotic pharmacology, including the work of Wikler[16] on conditioning, the initial goal—that of curing addicts—was never realized.

Persistent after effects of narcotic exposure also have been found in experimental animals. Physiological disturbances were demonstrated by Martin et al[17] and Cochin and Kornetsky[18] months after treatment of rats with morphine. Brase and associates[19] have used a small priming injection of morphine followed by naloxone as a probe to unmask residual abnormalities in rats long after exposure to narcotic drugs. Surprisingly, little new clinical research has been directed to the phenomenon of protracted abstinence despite the fact that relapse after completion of treatment is the central problem of narcotic addiction. With the present availability of sensitive analytic techniques, including specific ligands for analysis of receptor binding, the problem seems ripe for renewed investigation. What is needed now are methods to assess the kind and degree of receptor derangement in addicts and a better understanding of the function of this modulating system in response to physiological stress. With a more detailed understanding of addiction in molecular terms, a fundamental cure may be possible. Indeed, progress may come from work on other conditions in which chronic exposure to powerful nonnarcotic drugs leads, in susceptible persons, to persistent derangement of neurological[20,21] or endocrine[22] function.

PRACTICAL CONSIDERATIONS

None of these theoretical speculations should divert attention from the fact that methadone maintenance is an available treatment for otherwise intractable addicts. It is effective under a wide variety of conditions provided that an adequate, constant daily dose is given. Like digitalis, methadone can be lifesaving. Although it is now possible to provide a theoretical explanation for their beneficial actions, in practical terms, the justification for use of either methadone or digitalis, and the details of how they should be used, stem from experience.

The comparison goes deeper. No one questions the need for efforts to prevent the cardiac damage that ultimately leads to congestive failure or the importance of protecting young people from exposure to narcotic drugs. Prevention is fundamental in limiting the prevalence of these conditions. In principle, there should be no conflict between prevention of a disease and treatment of an established disability, and in the case of heart disease there is none. But with

drug addiction, a serious dilemma arises: limiting the supply of a dangerous drug, which is an essential part of prevention, can cause more damage to society than the addiction itself if extremes of enforcement promote criminal behavior. There is no simple answer to this dilemma. Obviously there should be a balance between enforcement and treatment, reducing both supply and demand proportionally. With heroin and related narcotics, methadone maintenance has by far the greatest immediate potential for reducing demand. It is therefore important that the medical profession understand its pharmacology, its indications, and its limitations.

The optimal daily dose of methadone for maintenance is the quantity that will hold the blood level in the 150- to 600-ng/mL range. This concentration range is consistent with binding to narcotic receptors when allowance is made for binding of methadone to plasma proteins and reduction in sensitivity of receptors with narcotic tolerance. As a general rule, 60 to 80 mg of oral *d,l*-methadone hydrochloride a day (reached by gradual increase over four to six weeks) is adequate and not excessive, although in exceptional cases substantially higher doses may be needed. If the activity of the hepatic microsomal enzyme oxidizing system has been increased by interaction with other medications being taken concurrently,[8,9] or for unknown reasons,[7] the elimination of methadone will be accelerated. In extreme cases, even 100 mg/d may fail to hold the blood methadone level within the therapeutic range for the full 24 hours and a higher divided dose will be needed for optimal results. However, these cases are unusual. Usually patients after stabilization for some months on a 60- to 80-mg/d dose can be lowered to the 40- to 60-mg/d range without difficulty. Some can be maintained successfully with even lower doses but, except, the rare cases in which full tolerance to the narcotic effects of methadone may not be developed, there is no compelling reason for prescribing doses that are only marginally adequate. As with antibiotics, the prudent policy is give enough medication to ensure success.

This perhaps is too casual an answer to the question of optimal dosage. If the instruments and funding required for repeated measurement of methadone blood levels were generally available (which they are not) it would be apparent that any rigid set of dosing guidelines would be misleading. The levels vary substantially from patient to patient receiving the same daily doses.[8,9] Analytic data, if available, would permit a fine-tuned adjustment of doses to optimal amounts for individual patients. Fortunately, this laboratory support is not needed. An experienced clinician can judge the adequacy of the dose from the effects. Symptoms of abstinence can be distinguished from anxiety, and narcosis from neurasthenia, by carefully listening to the symptoms, considering their timing in relation to the daily dose of methadone, noting the patient's response to a change in dose, and evaluating his or her emotional stability. The patient's clinical state is correlated reliably with the blood level and the degree of tolerance.

Some maintenance programs, committed philosophically to low-dose regimens, expose their patients to a significant degree of abstinence each day, as the blood level falls into the low range.[10] Other programs, seeing the medication as psychological rather than pharmacological treatment, give methadone as a reward for good behavior and withhold it for drug abuse and other infractions of rules. The results are generally poor, as might be expected from the fact that limiting or withholding medication that reduces drug hunger increases the need for illicit narcotics.

ALTERNATIVE THEORY

The hypothesis suggested herein—that narcotic-seeking behavior is a symptom of deranged receptor function—is most directly challenged by treatment of addicts with an antagonist such as naltrexone to block all narcotic actions. Use of antagonists stems from traditional views of addiction as a pleasure-seeking escape from reality employed by persons of weak will who are living in a stressful environment. Add to this the postulated influence of conditioned reflexes that generate an irresistible craving for narcotic when the addict is in the company of other drug users, and one has a theory of addiction.[11] The escapist-conditioning explanation is so plausible that it has influenced medical thinking and public health policy for three decades. Although this conception has never led to a treatment with consistent success, the failure has been excused by the practical difficulty of removing stress and bad companions from the environment of an addict and by the inability of counselors to eliminate character defects.

According to the conditioning theory, antagonist treatment, which blocks the narcotic effects of heroin and related drugs, should insulate the addict from temptation, especially after he has found them to be unrewarding. With no reinforcement, the interest in the narcotic should subside and the patient should become responsive to counseling. Again, there is an explanation for the repeated failures of antagonist treatment to stop heroin use during the past ten years: addicts can easily quit treatment and return to the illicit drug. Current research in some laboratories, aimed at development of implantable preparations of antagonist, is intended to close this loophole.

From the perspective of the receptor derangement theory, this approach is pharmacologically wrong. Antagonist drugs block the action of natural ligands as well as that of illicit narcotics. If the basic problem leading to relapse is a failure of the modulating system to return to normal function after withdrawal of narcotic, then antagonist treatment adds to the problem. The issue, therefore, is clearly drawn. If long-lasting, implantable preparations of narcotic antagonists prove to be as successful as methadone maintenance treatment in rehabilitation of addicts, this certainly would be a useful result. Further research is needed to determine whether the result was in fact due to deconditioning or to a positive interaction with endogenous opioid processes. On the other hand, if the treatment with implanted antagonist fails, then proponents of the conditioning theory should reconsider their position. This important experiment, if conducted, should be well documented and independently evaluated.

THE FUTURE

Apart from theory, the most striking fact is the physiological normality of maintenance patients. Persons who have taken a constant daily dose over a period of months to years are indistinguishable from normal peers. Despite a daily dose that would induce a coma in a naive patient, the patients are normally alert and functional; they live active lives, hold responsible jobs, succeed in school, care for families, have normal sexual activity and normal children, and have no greater incidence of psychopathology or general medical problems than their drug-free peers. Surprisingly, considering the constant input of narcotic, they have a normal response to painful stimuli, including specifically the warning symptoms of surgical emergencies.

All this does not fit neatly into the pharmacology learned from experiments involving single injections of narcotic drugs. The molecular biology of adaptation to chronic narcotic input must be better defined before we can fully understand the pharmacology of maintenance. Somehow the receptors adapt to a steady level of occupancy.

They react to a change in conditions, either in degree of receptor occupation by ligands or in the intensity of sensory stimuli, while being adapted to a constant high level of narcotic in tissue fluids.

Here, then, are basic questions to be answered by molecular biologists: How can this system function normally under such abnormal conditions? Why is stability of narcotic concentration more important than the absolute level? Are chronic adaptive changes completely reversible?

Needless to say, any attempt to relate behavioral disorders to molecular processes must start with an oversimplified model. Much more work is needed to take account of the diversity of narcotic receptors and endogenous ligands, the dynamics of receptor formation and internalization, the release of second messengers, and the interactions of modulating processes with other parts of the nervous system.[81,82] Nevertheless, the broad outline of a metabolic theory of narcotic addiction is coming into view. Two general conclusions emerge from the experience to date: it is not necessary to await an ultimate reduction of addictive behavior to molecular terms before effective treatment can be provided. On the contrary, effective treatment, empirically found, can lead to a better understanding of molecular processes.

This article is dedicated to the memory of Marie Nyswander, MD, who opened the modern era of treatment with her book *The Drug Addict as a Patient*.[83] Her experience and compassion guided the development of methadone maintenance.

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The Use of Insulin in the Treatment of Diabetes: An Analogy to Methadone Maintenance

J. Thomas Payte, M.D.*

A five-year study was conducted on 300 insulin-dependent diabetics. The purpose of the study was to determine if the use of insulin resulted in any long-term benefit to diabetics. The concept was based on two widely accepted hypotheses: (1) that a formerly insulin-dependent diabetic could learn to live a comfortable and responsible life without insulin, provided that he or she wanted to badly enough; and (2) that the use of any exogenous substance to replace or simply substitute for a deficient endogenous substance is conceptually unacceptable to modern scientific thinking and may be inherently evil.

It is obvious that exogenous insulin, being highly suspect at the outset, should be used in the lowest possible doses and for the shortest time possible. In this study, treatment with insulin was limited to two years and the daily dose was limited to a maximum of 40 units. The posttreatment follow-up period varied from three days to three years, depending on the duration of survival. During the treatment phase (insulin maintenance), random urine samples were collected under direct supervision and tested for glucose at least weekly. A positive urine glucose resulted in a warning to the patient. After three positive urine tests, the dose of insulin was reduced by five units daily for each positive urine test. This policy was intended to increase motivation on the part of the patient to provide urine specimens negative for glucose. If positives continued, the insulin was eventually discontinued and the patients were placed in the follow-up group. The authors of the study felt that patients would have a better chance of reentry into insulin maintenance at a later date if (a) patients survived and (b) patients accepted full responsibility for their insulin dependence and were willing to go to any lengths to recover.

All patients were required to endure one hour of individual or group counseling each week, which addressed such subjects as meal planning, hygiene for the feet, pancreatic imagery, and dietary assertiveness. Counseling patients fell into one of three categories: those who had no need or desire for counseling; those who might need counseling but were entirely unwilling to participate; and those who both wanted and needed extensive counseling, but the counselors were so busy spending an hour a week with the others that they were unable to meet the increased demands and needs of this group. Avoiding this bothersome, time-consuming, and costly process of individualized treatment also served to reduce the risk of enabling the patients' maladaptive behaviors by what could seem to be a reward system. The resulting uniformity of service assured that the needs of *no one* were met. It was hoped that by making the treatment unpleasant that motivation for recovery would be enhanced.

Half of the participants failed to complete the two-year treatment with insulin maintenance. Some patients simply dropped out of treatment, but most were terminated for continued glucose-positive urines. This was despite repeated warnings and in absolute defiance of the reductions in insulin dosage with each glucose-positive urine. It was concluded that this population is poorly motivated, difficult to work with, and is lacking the resources needed

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to effect the major life changes required for recovery. Many of this group died during follow-up. Some survived with amputations, blindness, neuropathies, and other conditions associated with the unhealthy life-styles of the diabetic.

The remaining half did manage to complete the two-year treatment and even appeared to experience relatively good health and seemingly normal functioning. Of course, this illusion of apparent good health was at the [illegible] to maintain the insulin-dependent status with daily insulin. Some investigators speculated that insulin might be continued over a longer period of time and at higher doses. This notion was quickly rejected as being absurd because good health should not be obtained at just any cost. As the patients approached the two-year period, the insulin doses were tapered over the final two months. All subjects began having positive urine tests and again were showing active insulin-dependent diabetes. The obvious conclusion is that insulin does not help the insulin-dependent diabetic and is not effective in treatment. The high mortality rate of posttreatment patients suggests that insulin may have had some delayed, deadly toxic effects. This concept should be the subject of future research.

COMMENT

This "insulin spoof" was originally written with the idea to share it among friends and colleagues. Somewhat surprisingly, the spoof was well received by many who urged that it be shared with a wider audience. Initially, the intention was to transpose rather typical and illogical clinical thought processes about methadone maintenance to another more familiar chronic and incurable disease. [illegible] with more widely understood made the line of reasoning clearly absurd in the new context. Yet when this psuedologic is applied to chronic opioid dependence and methadone maintenance, few people find anything wrong or out of place. One might conclude that the vision of some is clouded by the philosophical and ideological considerations that erect barriers to understanding, accepting, and implementing this lifesaving treatment modality for those chronic intractable heroin addicts who need it.

Any humor in this parody is quickly lost when one estimates the loss of life and other costs associated with untreated heroin addiction that can be attributed to a persistent shortage of methadone treatment slots. This shortage is due, in part, to persistent negative attitudes toward the methadone treatment modality.

One of Medicine's Best-Kept Secrets: Methadone Works

Greatest success stories go untold because of stigma.

By CHRISTOPHER S. WREN

BACK when a subway ride cost 15 cents, Dr. Vincent Dole, a metabolic specialist, and Dr. Marie Nyswander, a psychiatrist, joined forces to try to reverse a worrisome rise in heroin addiction in New York City.

Working at the Rockefeller Institute, as Rockefeller University was then called, the researchers sought to block addicts' craving for heroin by substituting an opioid painkiller developed by German chemists during World War II.

More than three decades later, the synthetic analgesic they first tested in 1964, methadone, is accepted as the closest thing to a heroin cure. About 115,000 Americans take methadone regularly.

Yet by various estimates, only 5 percent to 20 percent of such users stay on it for more than 10 years. Some find they no longer want the medication. Others relapse into drug use. Many are put off by the cumbersome, often petty bureaucracy that administers methadone; misleading rumors that methadone is ruinous to health; and an insidious social stigma that by equating methadone with illicit drugs, forces users to hide the achievement of taking back their lives.

"Successful methadone users are invisible," said Dr. Edwin A. Salsitz, director of the methadone medical maintenance program at Beth Israel Medical Center in New York City. "Methadone is always judged by the failures."

One success story is James K. Maxwell. With his white beard and twinkling blue eyes, Mr. Maxwell resembles the poster grandpa for a bygone America. He confesses to having turned 80, brags about his four grandsons, and remarks, "No granddaughters — very disappointing."

As the hard-driving trumpet player Jimmie Maxwell, he toured with Benny Goodman and went on to perform with the bands of Lionel Hampton, Duke Ellington and Gerry Mulligan. He worked for years as a studio musician on the Perry Como radio and television show and Johnny Carson's "Tonight Show."

"I don't think I missed a day of practice in more than 60 years," he said. "People say, 'Why do you want to play?' and I say, 'That's what I do. I'm a trumpet player.'"

But Mr. Maxwell has a darker story to tell. In the prime of his career, heroin nearly killed him. He has stayed clean by taking methadone every day for nearly 32 years.

His wife of 55 years has known, of course, but hardly anyone else — not his employers or his neighbors in Great Neck, N.Y., or his best friend, a retired Federal drug agent. "Just for reasons of my career, I didn't talk about it," Mr. Maxwell said.

In that he is hardly alone. Because of its association with heroin, those benefiting most from methadone are least likely to risk their careers or reputations by saying so.

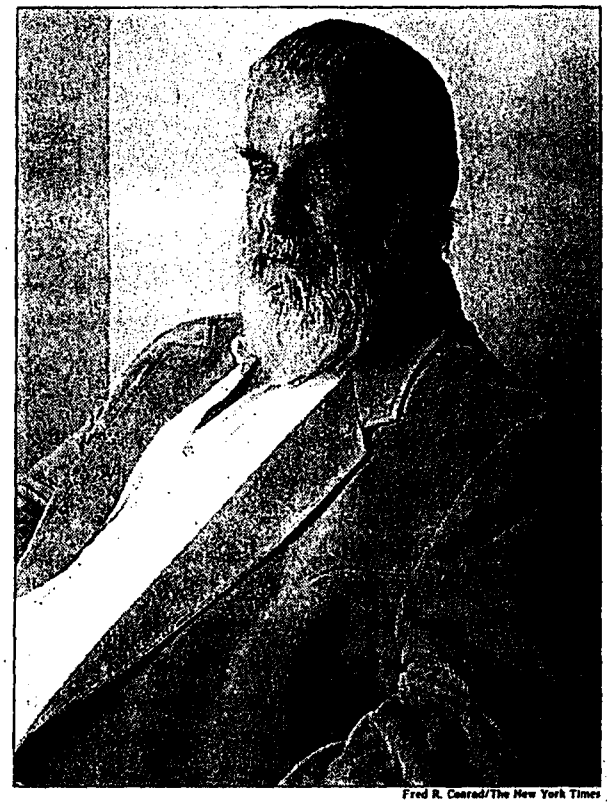
The stigma surrounding methadone was analyzed by Herman Joseph, a research sociologist who worked with Dr. Dole and Dr. Nyswander. Even an innocent yawn, he reported, can jeopardize a methadone user's job if the boss or coworkers mistake it as drowsiness induced by methadone rather than routine fatigue.

Yet the extensive medical literature on methadone does not contain a single report of methadone's failing to block the craving for heroin. "The safety and efficacy of methadone in the treatment of narcotic addiction have been documented more extensively than any other medication in the pharmacopeia," said Dr. Robert G. Newman, president of Beth Israel Medical Center.

Regular doses of methadone break the heroin user's wild swings between euphoria and withdrawal by stabilizing the level of opiates in the bloodstream. Dr. Nyswander's experience with the relapses of detoxified addicts persuaded her that they could not shake heroin without substituting a less harmful narcotic.

"Marie was convinced that addiction was a disease and had to be treated with pharmacotherapy," said Dr. Mary Jeanne Kreek, an early colleague of Dr. Nyswander. Dr. Kreek now heads the Laboratory of the Biology of Addictive Diseases at Rockefeller University.

When the first patients were given up to 80 milligrams of methadone once a day in double-blind studies lasting eight weeks, Dr. Kreek said, "they began turning away from drug administration and getting on with their lives." The researchers found that a dose of 80 milligrams of methadone, costing less than a dollar, could block the effect of $200 worth of heroin bought on the street.



Fred R. Conrad/The New York Times

Those benefiting most from methadone are least likely to talk about it. Jimmie Maxwell, veteran jazz trumpeter, has taken it for nearly 32 years.

Methadone is practical and effective, Dr. Kreek said, because it can be taken by mouth, its effects are felt gradually and it wears off slowly. Half of it remains in the body after 24 hours. In contrast, heroin's euphoric rush lasts only minutes.

Minor side effects of methadone, including sweating, constipation and a reduced sex drive, tend to disappear when patients adjust to the medication. Dr. Kreek, who has been studying methadone use for 33 years, reported, "There's no deleterious effect, physiologically or in terms of any medical condition, with the use of methadone, including doses of up to 120 milligrams a day."

Still, methadone has its skeptics like Dr. Mitchell Rosenthal, president of Phoenix House, whose nationwide treatment programs strive for total abstinence. "Methadone is a very useful drug for a limited number of people," Dr. Rosenthal said. "It has been oversold for a wide number of people." Because many addicts abuse multiple drugs and have limited education and job skills, he said, "they are not going to be chemically fixed by giving them another drug."

Dr. Salsitz agreed, "Methadone can't give you a job, or good manners or make you literate." But for healing the medical symptoms of heroin addiction, Dr. Salsitz equates methadone with what insulin is for diabetics and other medicines are for high blood pressure.

Indeed, Mr. Maxwell was able to record a hauntingly mellow jazz album, "Let's Fall In Love," while on methadone.

"He's a classic case of somebody who responded well to the treatment," Dr. Salsitz said. "He's exactly the right kind of person for it."

Mr. Maxwell said that almost no one in his crowd used heroin, a drug more popular with be-bop musicians like Charlie Parker. "Three or four persons were in the same fix I was in," Mr. Maxwell recalled, "but most musicians tended to drink."

But during a tour of the Soviet Union with the Benny Goodman band in 1962, Mr. Maxwell contracted a debilitating diarrhea that Soviet doctors treated with spirits of laudanum, which is opium dissolved in alcohol. He completed the tour and returned exhausted to New York, where an acquaintance suggested trying a white powder — heroin — to restore his strength. He snorted it for the next three years, though he recalled, "I didn't have all that pep when I was using heroin. I played much better without it."

Heroin left him nearly broke and he considered suicide. Instead, Mr. Maxwell sought help from Dr. Nyswander, who put him in her program in 1965. He has been free of heroin since, he said, without adverse effects. "When I went on the program, it just stopped," Mr. Maxwell said. "I had no reason to use drugs."

Though methadone is classified as a narcotic, Mr. Maxwell said it never gave him a buzz. "I thought it would make you feel good but it doesn't," he said. "It's a negative thing. It prevents you from feeling bad."

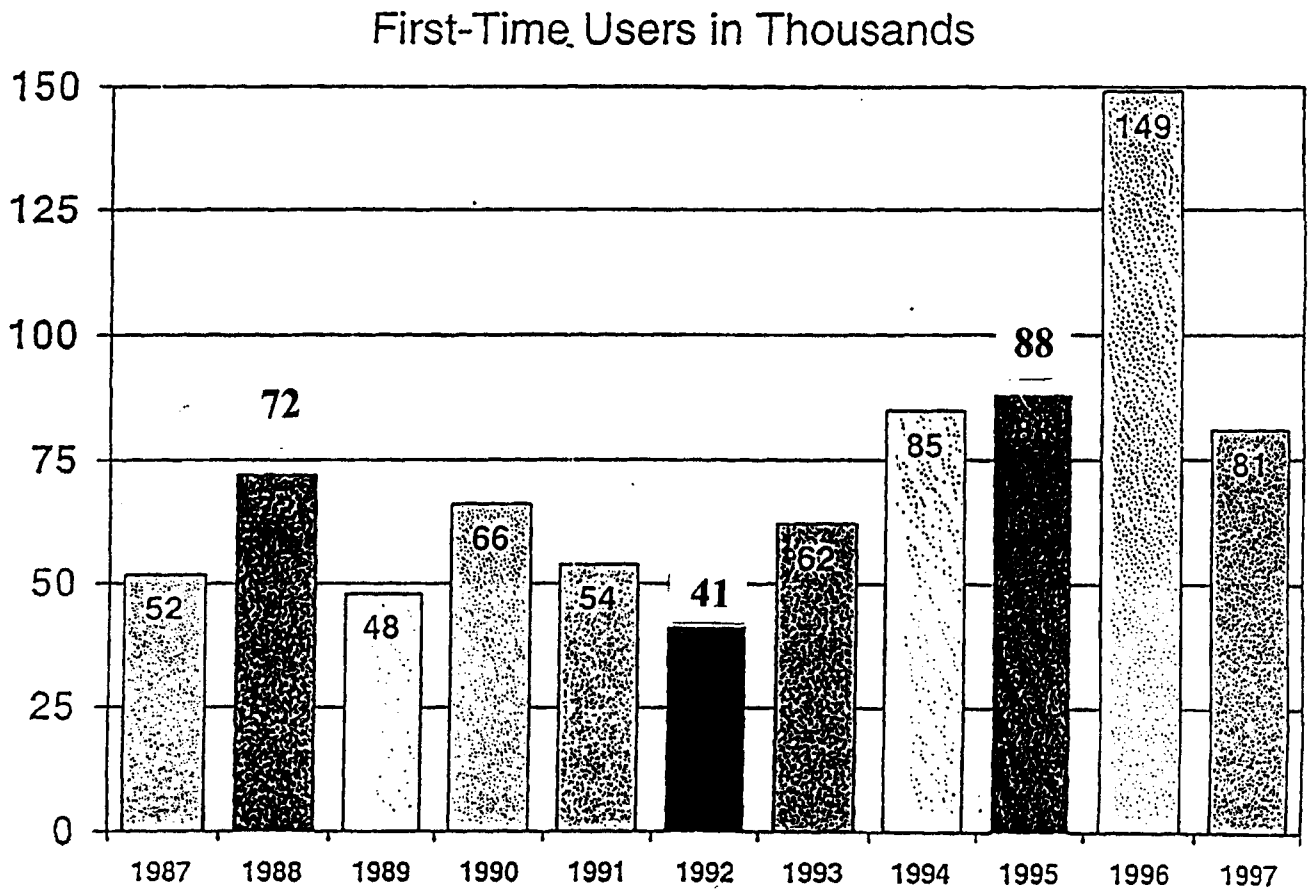
For years, Mr. Maxwell slipped away between performances and rehearsals to drink his methadone at a clinic. In 1983, he transferred into Dr. Salsitz's program at Beth Israel, which lets patients pick up a four-week supply of soluble tablets. The program, which no longer accepts new patients, costs $90 a month, including the methadone, an office visit with Dr. Salsitz and access to primary health care.

Afterwards, Mr. Maxwell heads down to Chinatown for lunch with his friend, the retired drug agent, before going home to his wife, Gertrude, in Great Neck. And every morning, he dissolves another salmon-colored diskette containing a modest 40 milligrams of methadone.

"It's just another pill that I take," he said. "It takes away the drug way of thinking."

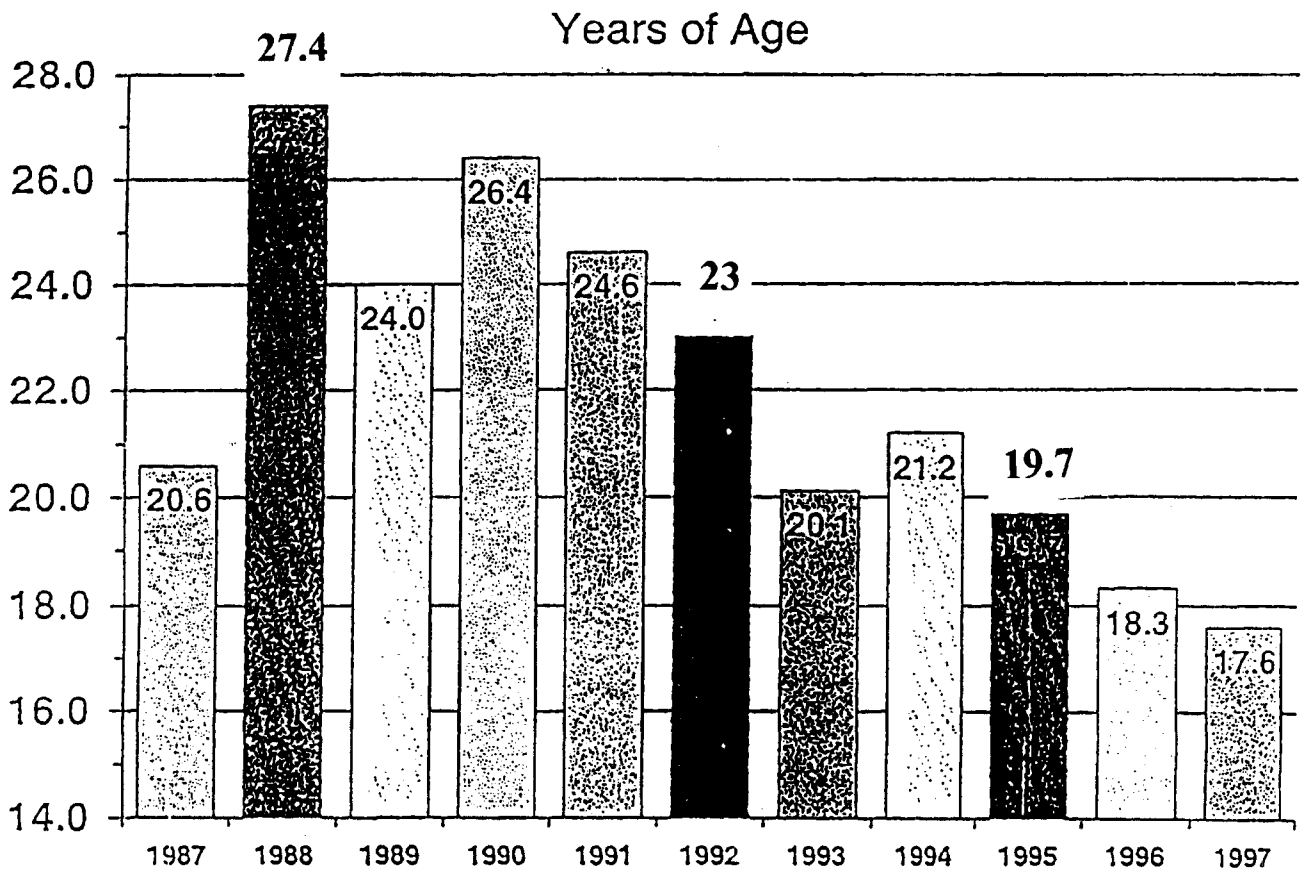
PHARMACOTHERAPY AND ITS ROLE IN OPIOID DEPENDENCY TREATMENT

Heroin Initiation Rates



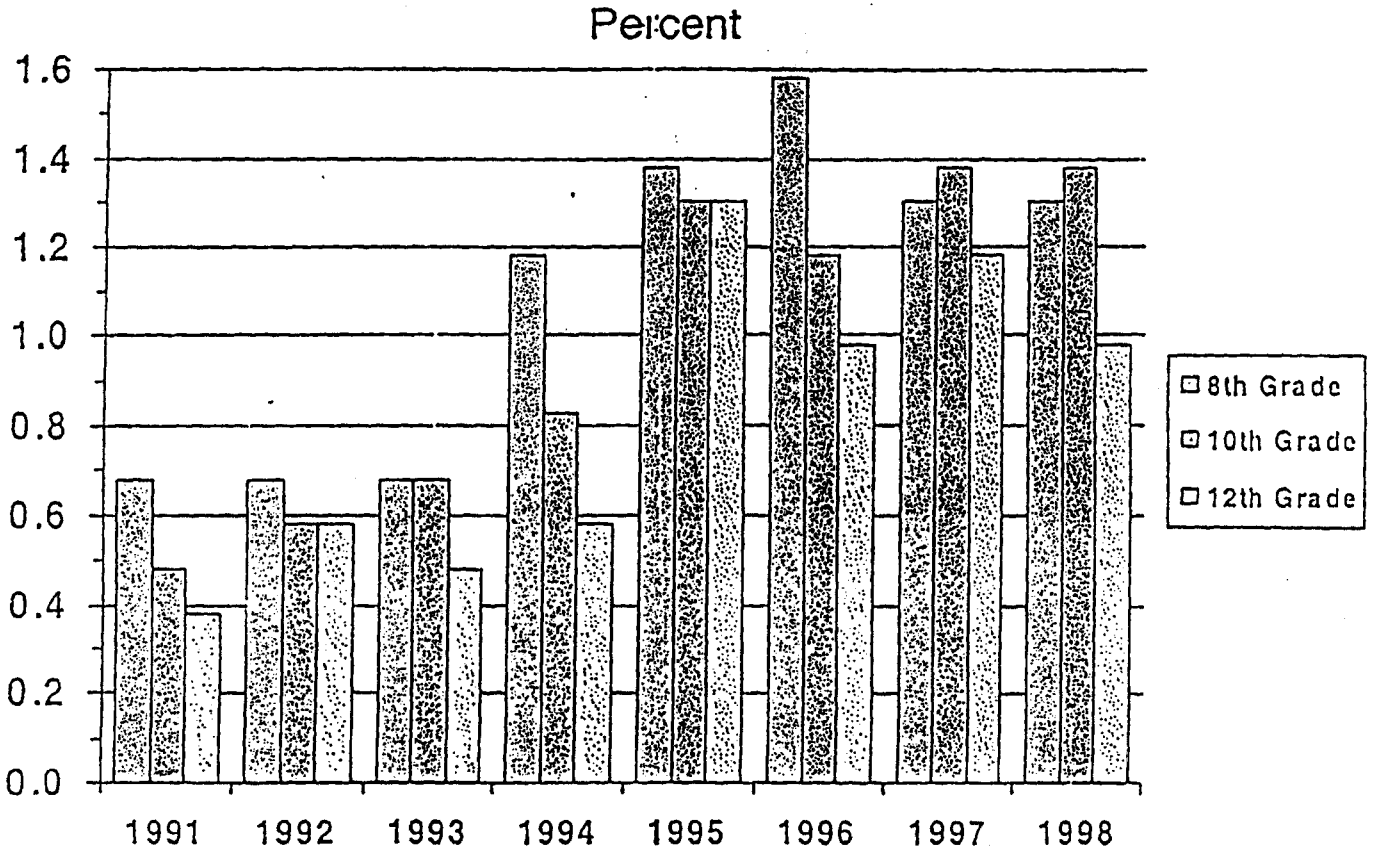
Source: SAMHSA, 1998 National Household Survey on Drug Abuse

Average Age of First Heroin Use



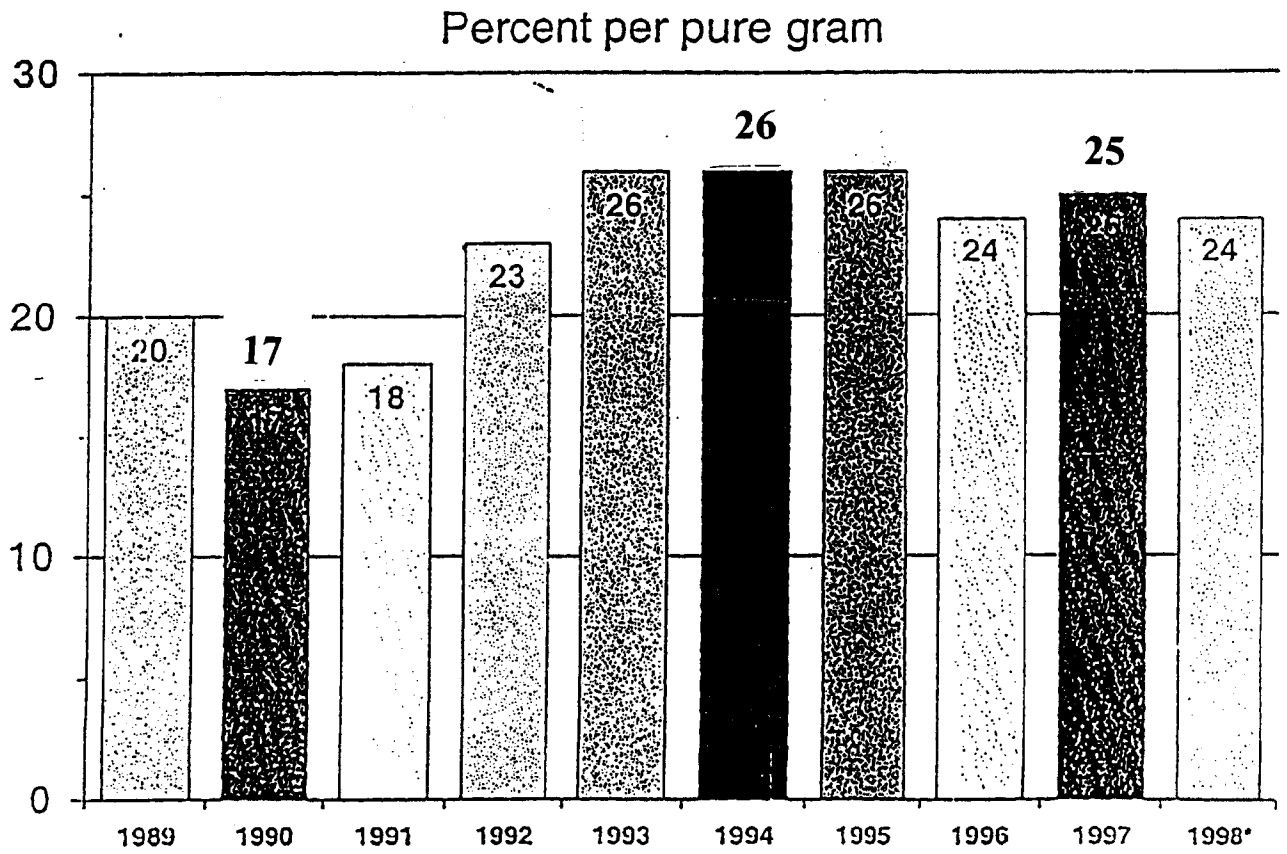
Source: SAMHSA, 1998 National Household Survey on Drug Abuse

Prevalence of Heroin Use Among Students



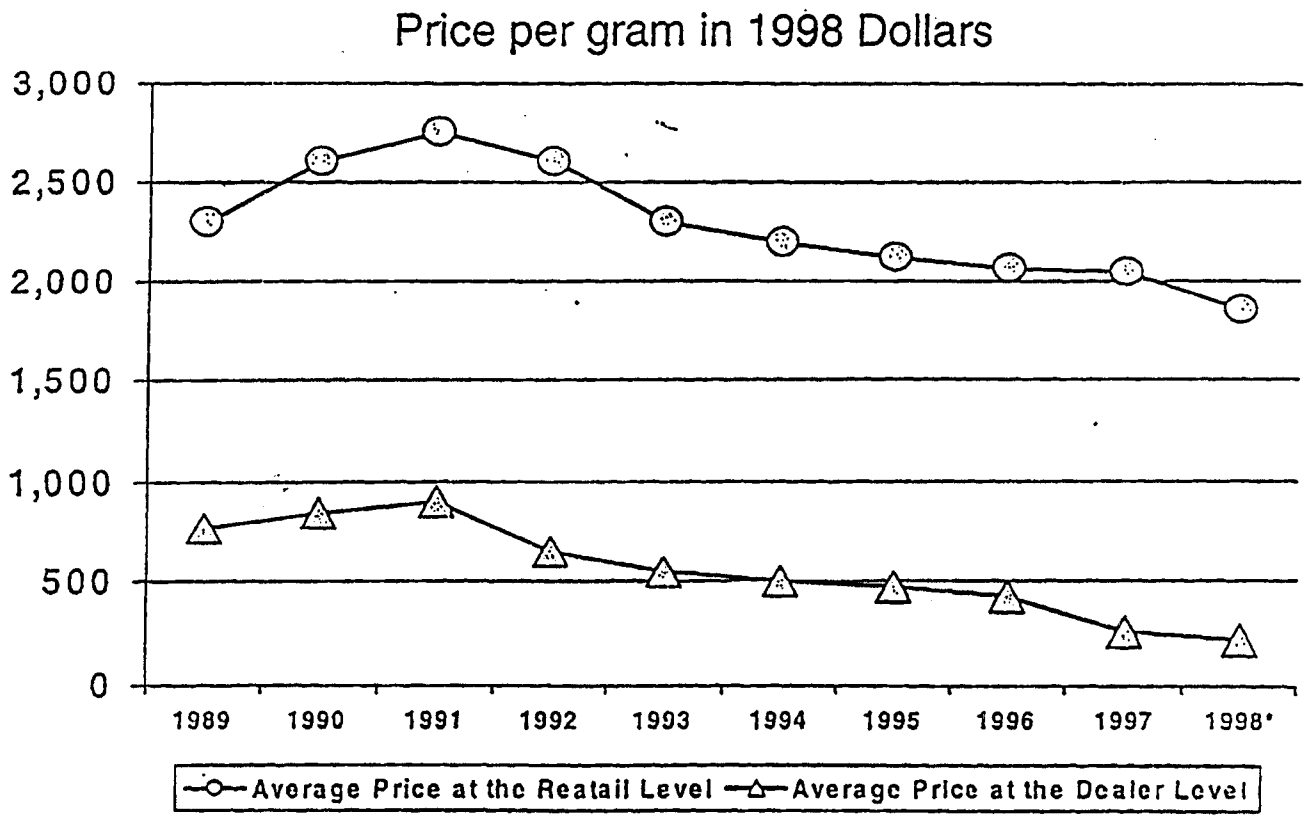
Source: Monitoring the Future Study

Heroin Purity at the Retail Level



**Based on annualized data through June 1998*
Source: 1999 ONDCP—Adjusted from DEA STRIDE Data

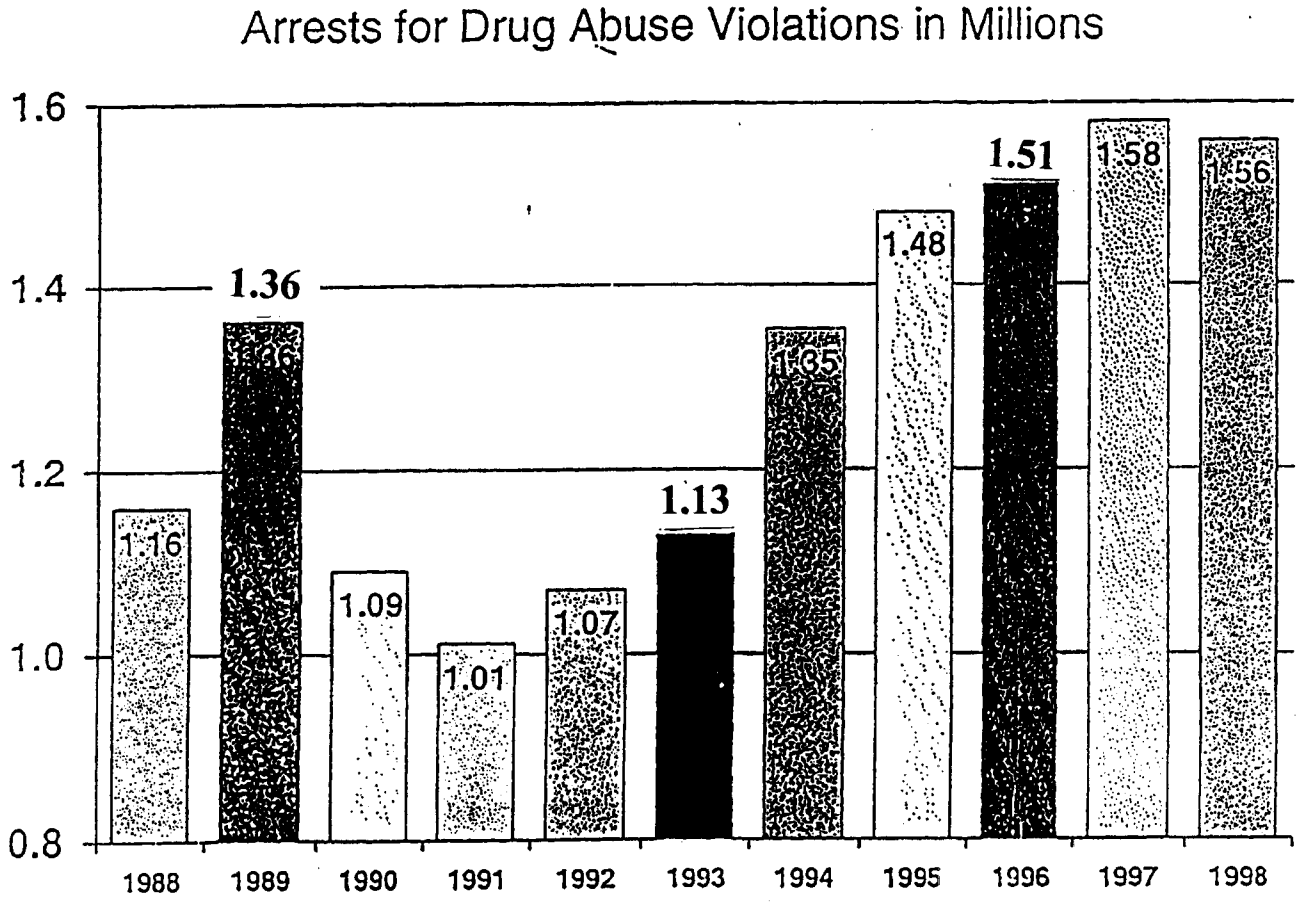
Average Price for Heroin



**Based on annualized data through June 1998*

Source: 1999 ONDCP—Adjusted from DEA STRIDE Data

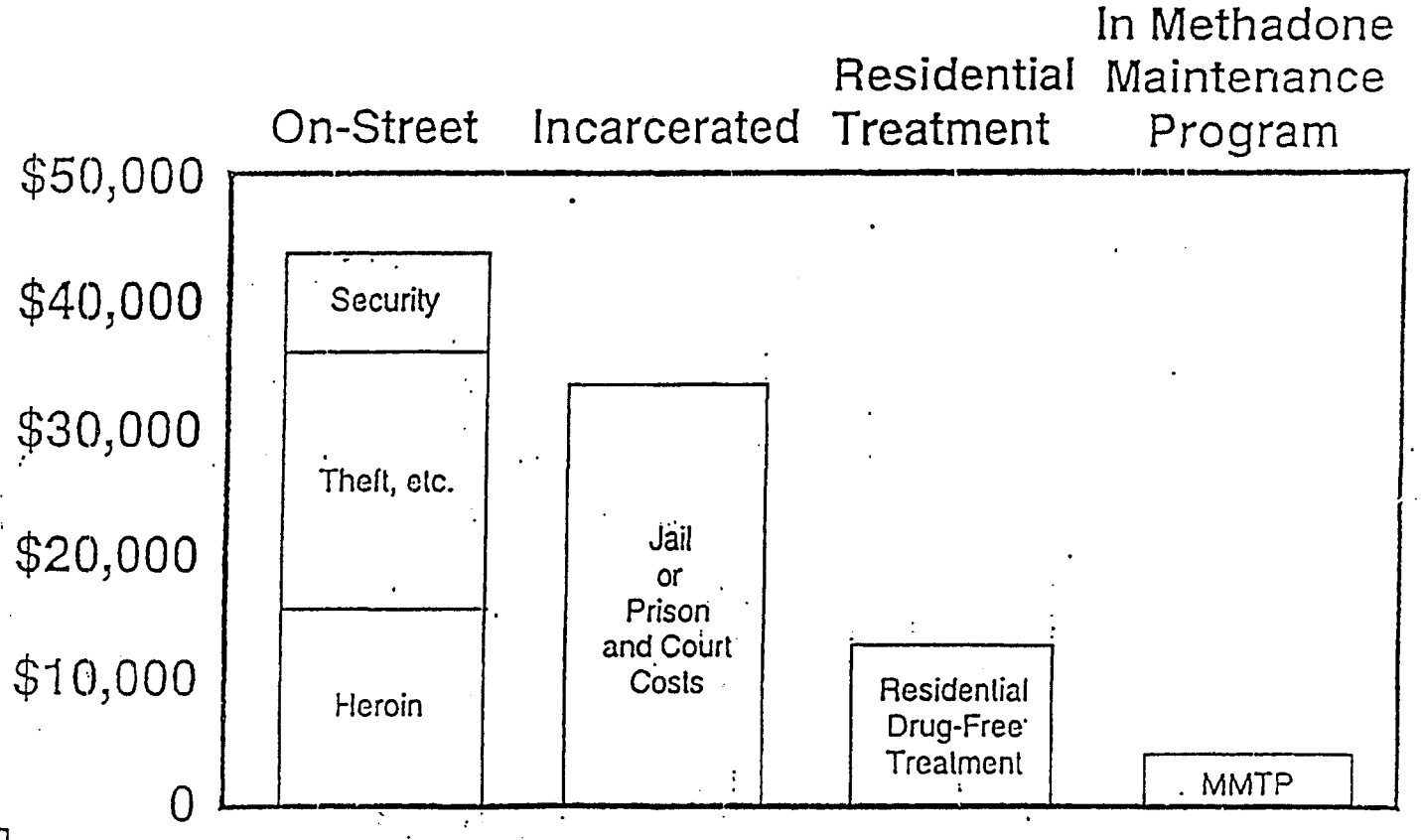
Drug-Related Arrests



Source: 1999 FBI Uniform Crime Reports

AVERAGE COSTS PER YEAR FOR ONE HEROIN ADDICT

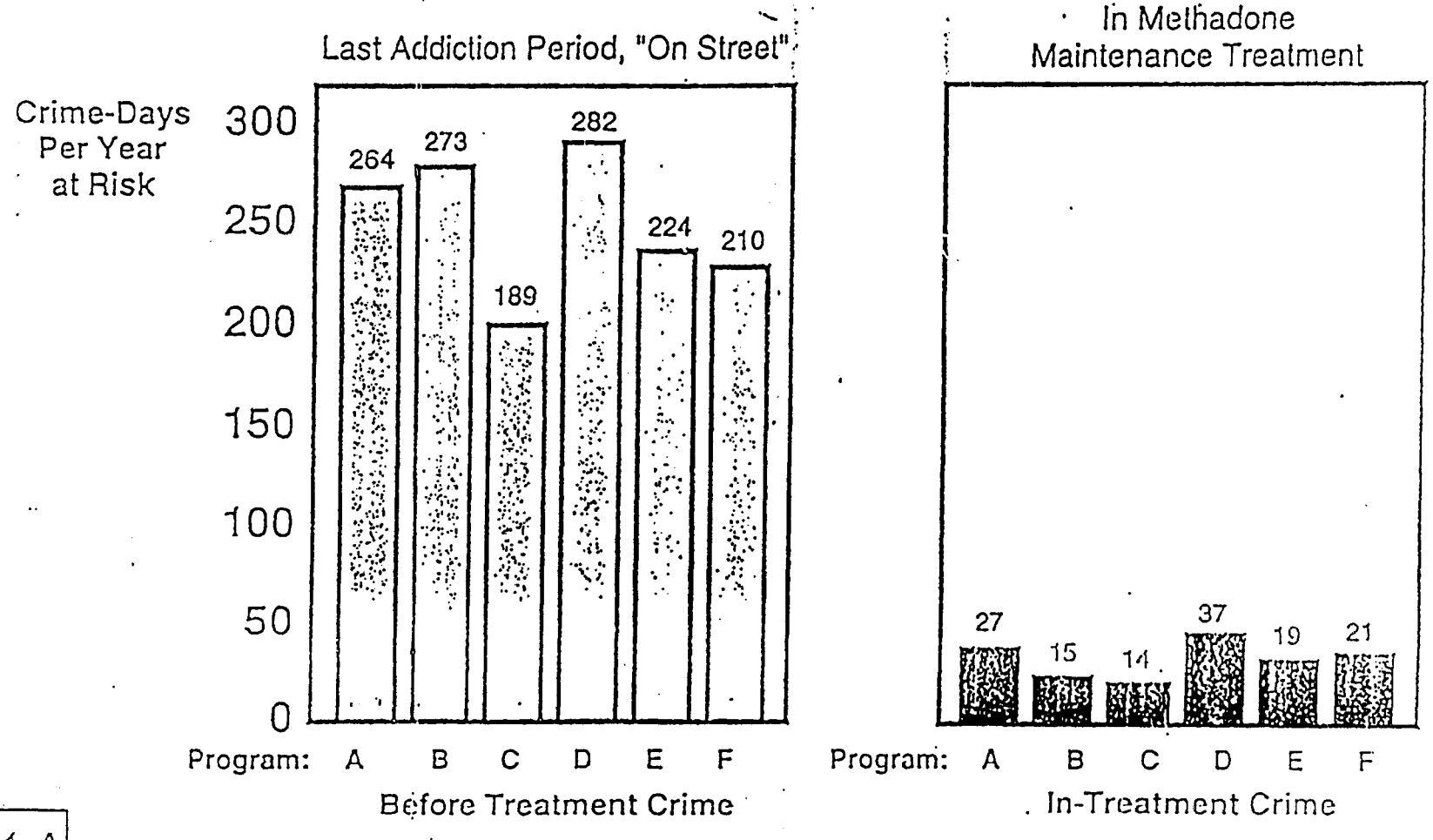
(Adapted from New York State Division of Substance Abuse Services, 1991 by Dole and DesJarlais)



V10-A

CRIME BEFORE AND DURING MM TREATMENT AT 6 PROGRAMS

(Ball and Ross, 1991)

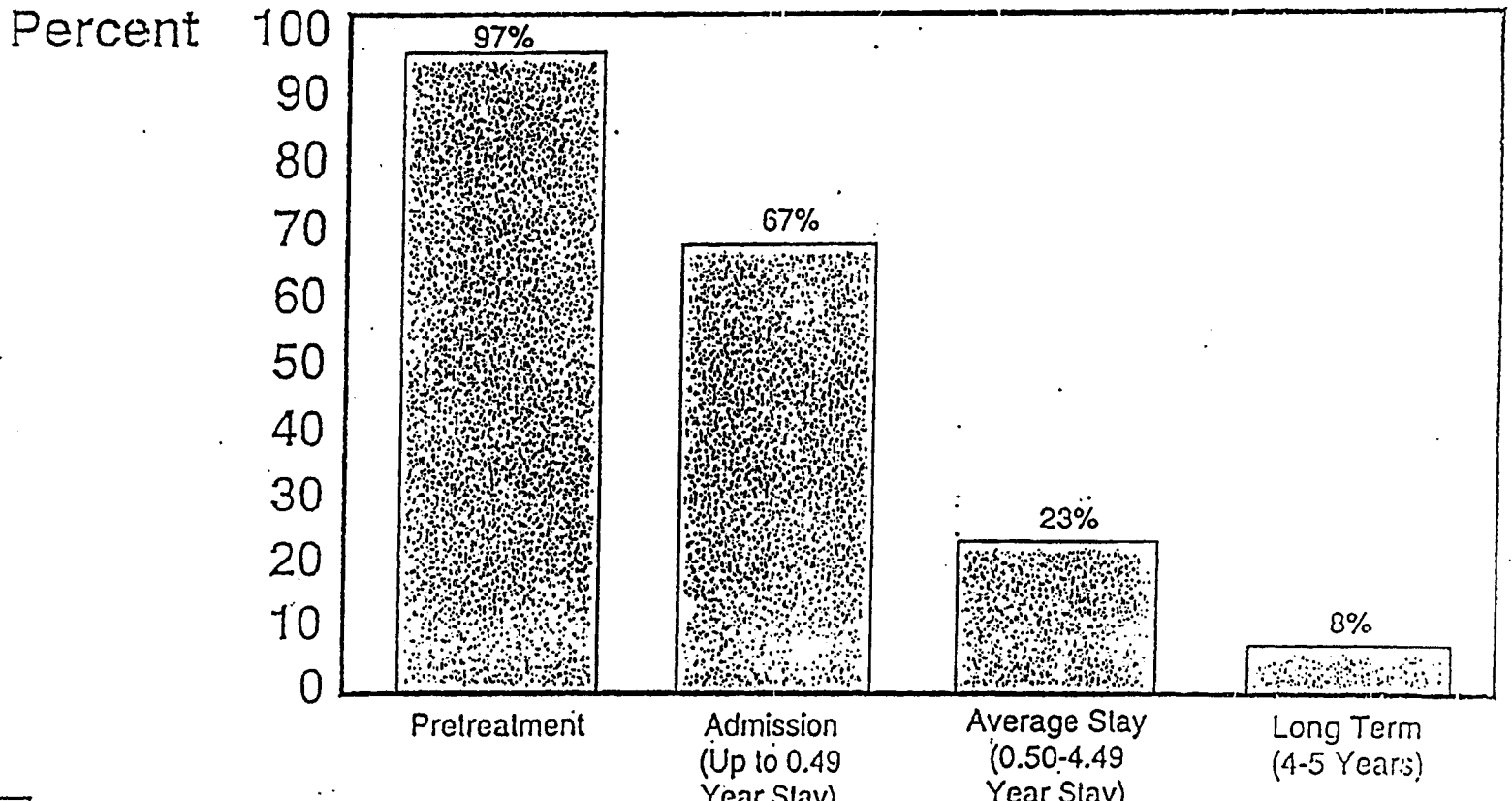


V4-A

Grey bars = crime-days per year when addicted. Solid bars = crime-days per year after 6 months or more in treatment. (N = 491)

REDUCTION OF HEROIN USE BY LENGTH OF STAY IN MM TX

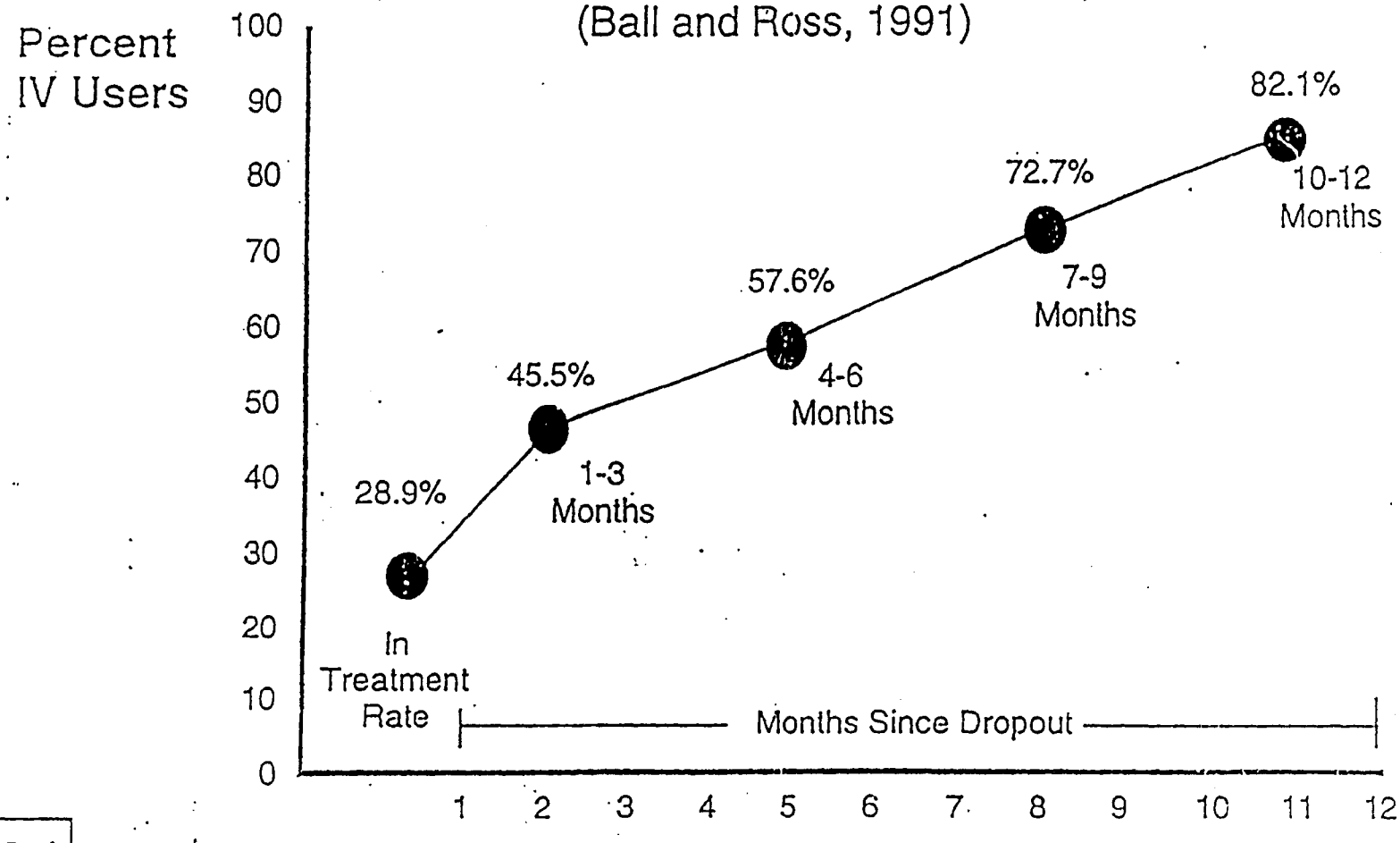
(Ball and Ross, 1991)



V2-B

RAPID RETURN TO INJECTION DRUG USE FOLLOWING PREMATURE TERMINATION OF MM TX

(Ball and Ross, 1991)



V6-A

(N = 105 male patients)

The Rikers Island Methadone Program, 1998

- The cost of outpatient methadone treatment is about $4,700.00 per year and involves the use of medication in addition to medial care and counseling, compared to the per person cost of $18,400.00 for one year of imprisonment.

- The Rikers Island Program treated 4,431 inmates with methadone in 1998.

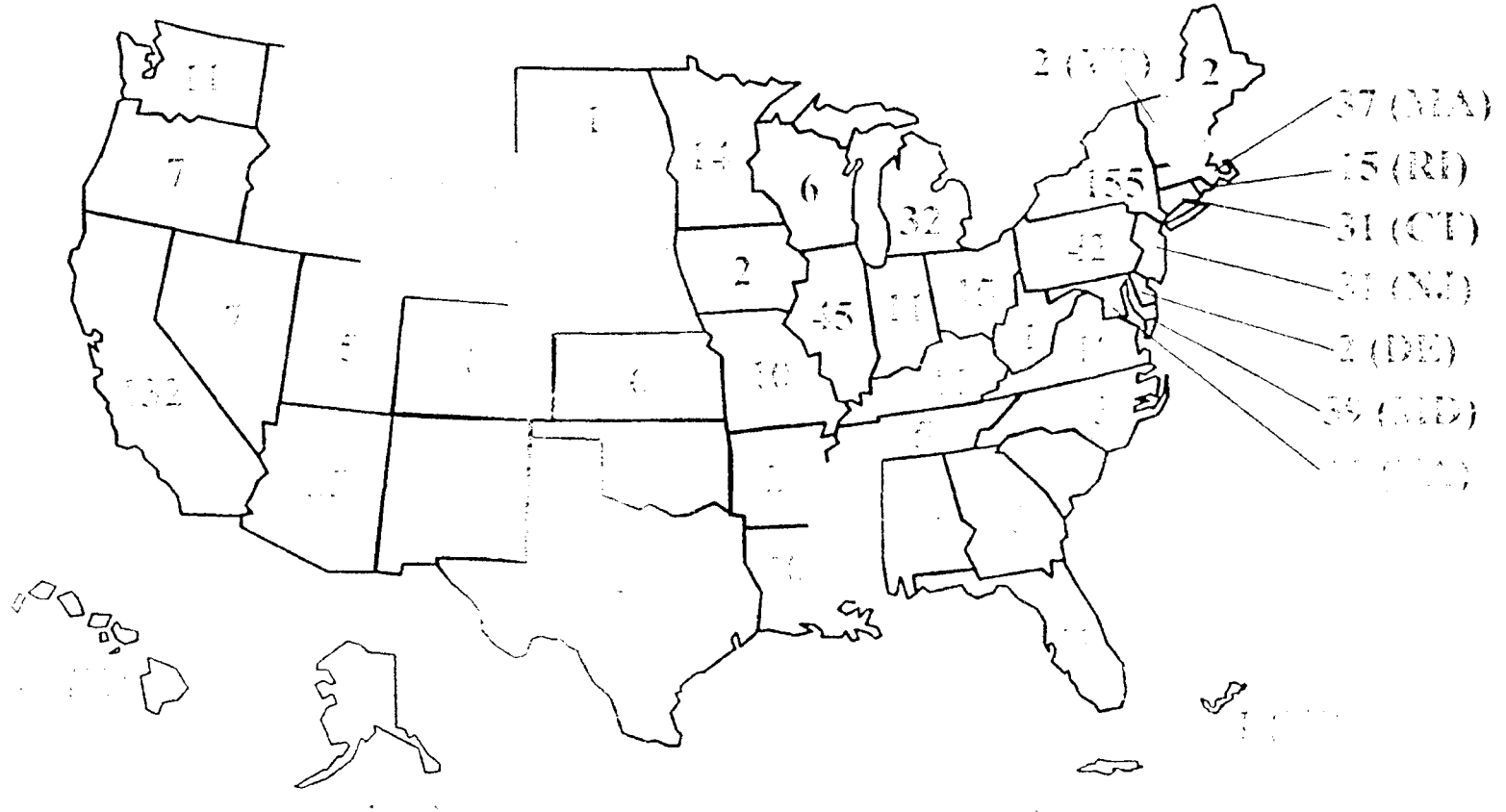
- Approximately 70 percent of these inmates were men and 10 percent of the women in the program were pregnant.

- The average KEEP patient's length of stay in 39 days at Rikers Island.

- Seventy-nine percent of all inmate patients reported to their assigned programs for continued substance abuse treatment following their release from jail.

SAMHSA

ACTIVE NTPs IN THE U.S.



Center for Substance Abuse Treatment

Current Inventory of Regulated OTPs

- 1,000-1,200 Opioid Treatment Programs (OTPs)
  - Certified by SAMHSA/CSAT
  - Resitered by DEA
  - Licensed by State
- 950 Maintenance, 250 Detoxification
- approximately 205,000 Patients in Treatment

SAMHSA

Federal Opioid Treatment Standards (§8.12)

- Administrative and organizational structure
- Quality assurance/improvement
- Diversion Control Plan
- Staff credentials
- Patient admission criteria
- Required services
- Record keeping and patient confidentiality
- Medication administration, dispensing
- Unsupervised use
- Interim maintenance
- Detoxification

Treatment Standards

- Required Services
  - Medical
  - Counseling
  - Periodic Assessment and Treatment Plans
- Admission Criteria
  - Detoxification and Maintenance
- Drug Abuse Testing
  - Quality Control, Outcome Assessment - New
- "Take-homes" and solid medications

Take Home Schedule - 6 Steps

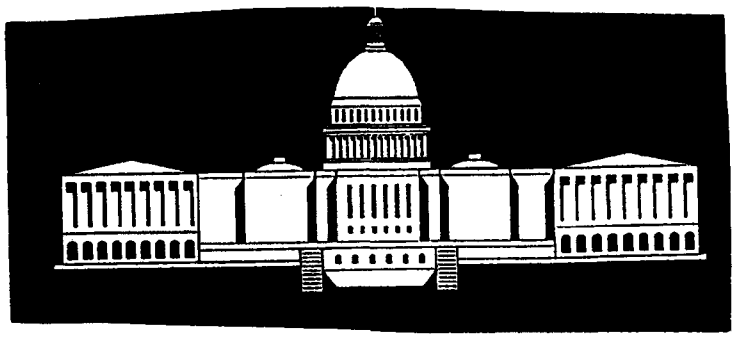
- A patient may receive a single take home dose for a day the program is closed, AND
  - 0-90 days - patient may receive a single dose each week
  - 90-180 days - patient may receive up to two doses per week
  - 180-270 days - patient may receive up to three doses per week
  - 270-365 days - patient may receive up to six doses per week
  - After 1 year continuous treatment - up to a 2 week supply
  - After 2 years of continuous treatment - up to a 30 day supply

Phases of Treatment - Continuum

- Medical Maintenance - 14-30 day take-homes-bimonthly/monthly reporting
- Medical Maintenance w/ off site physician affiliated with on OTP, treating stabilized patients (10 approved)
- Medical Maintenance w/ off site physician and pharmacy dispensing (2 approved) solid med.
- Office-based treatment w/non stabilized pts, non affiliated physicians (0 approved)

New Law - DATA 2000

- NATA Waived - no separate registration for certain physicians and certain drugs
- Prescribing permitted
- Requires evaluations by HHS and DEA
- Preempts State laws
- 30 Patients per physician



TREATING THE PHARMACOTHERAPY CLIENT IN A "DRUG FREE" FACILITY

SSTARBIRTH: Client Participation in Methadone Maintenance

Table 1 illustrates client participation in methadone maintenance during enrollment in SStarbirth, for 145 women enrolled in the program between October 1, 1993 and August 30, 2002. A total of 21 women have participated in methadone maintenance while in treatment at SStarbirth.

Table 1: Client Participation in Methadone Maintenance (n=145)

Program Year	# Enrolled	% (#) Participating in Methadone Maintenance	% (#) Not Participating in Methadone Maintenance
10/1/93 - 9/30/94 (9 months of admissions)	12	0% (0)	100% (12)
10/1/94 - 9/30/95	15	0% (0)	100% (15)
10/1/95 - 9/30/96	16	6% (1)	94% (15)
10/1/96 - 9/30/97	16	19% (3)	81% (13)
10/1/97 - 9/30/98	19	16% (3)	84% (16)
10/1/98 - 9/30/99	22	29% (6)	71% (16)
10/1/99 - 9/30/00	13	8% (1)	92% (12)
10/1/00 - 9/30/01	17	18% (3)	82% (14)
10/1/01 - 8/30/02* (11 months)	15	27% (4)	73% (11)
TOTAL	145	14% (21)	86% (124)

The number of current clients participating in a methadone maintenance program is 2. Of the remaining 19 women, 11 of these women (58%) completed treatment and 8 (42%) left treatment prematurely (these clients remained in treatment between 2 weeks and 10 months). The program completion rate for all clients at SStarbirth who did not participate in methadone maintenance is the same: 66 (58%) completed treatment and 48 (42%) left treatment prematurely.

DEPARTMENT OF MENTAL HEALTH, RETARDATION & HOSPITALS
Division of Behavioral Healthcare Services

Request for Client Dual Enrollment

Date: _____ Client Identifier: _____

The client identified above is currently enrolled in the_____ Narcotic treatment/Residential/Day Tx program. It is jointly requested by the undersigned that approval by the Division of Substance Abuse is given for dual enrollment for this client in the _____NTP/Residential/Day/ treatment program based upon the following clinical indications:

Criteria: Level of Service (Intensity) ***Please check high, medium or low for each dimension. Give brief discription under each dimension.***

Dimension 1 Acute Intoxication and/or Withdrawal Potential
Low ☐ Medium ☐ High ☐

_____

_____

Dimension 2 Biomedical Conditions and Complications
Low ☐ Medium ☐ High ☐

_____

_____

Dimension 3 Emotional/Behavioral Conditions and Complications
Low ☐ Medium ☐ High ☐

_____

_____

Dimension 4 Treatment Acceptance/Resistance
Low ☐ Medium ☐ High ☐

_____

_____

Dimension 5 Relapse/Continued Use Potential
Low ☐ Medium ☐ High ☐

_____

_____

Dimension 6 Recovery Environment
Low ☐ Medium ☐ High ☐

Additional comments describing intensity of services:

Authorized Signature,
Narcotic Treatment Program

Authorized Signature,
Residential/Day Treatment Program

Division of Substance Abuse use only

Approval granted/date_____ Approval denied/date_____

Signature, Chief of Treatment Unit or designee_____

11/1/99
Revised: 08/05/02

DEPARTMENT OF MENTAL HEALTH, RETARDATION & HOSPITALS
DIVISION OF SUBSTANCE ABUSE

Request for Client Dual Enrollment

Date: 7/27/00 **Client Identifier: SAM-0007**

The client identified above is currently enrolled in the **RI DSA** Narcotic treatment/Residential/Day Tx program. It is jointly requested by the undersigned that approval by the Division of Substance Abuse is given for dual enrollment for this client in the **RI DSA-IV** NTP/Residential/Day/ treatment program based upon the following clinical indications:

Criteria: Level of Service (Intensity) ***Please check high, medium or low for each dimension. Give brief discription under each dimension.***

Dimension 1 Acute Intoxication and/or Withdrawal Potential
Low ☐ Medium ☐ High ☐

Pt. is dually addicted to narcotics and alcohol. She reports daily use of alcohol: Hx of blackouts, and on two occasions she had hallucinations when trying to stop.

Dimension 2 Biomedical Conditions and Complications
Low ☐ Medium ☐ High ☐

Patient is diagnosed with Hep. C and is inconsistent with getting proper medical attention.

Dimension 3 Emotional/Behavioral Conditions and Complications
Low ☐ Medium ☐ High ☐

Patient is diagnosed with bi-polar disorder and currently being seen bi-weekly at Pawtucket Mental Health Ctr. She is prescribed lithium. Inconsistant med compliance.

Dimension 4 Treatment Acceptance/Resistance
Low ☐ Medium ☐ High ☐

Patient admits need for higher level of care but identifies life circumstances which she claims will make enrollment difficult

Dimension 5 Relapse/Continued Use Potential
Low ☐ Medium ☐ High ☐

Patient has tried numerous times to stop alcohol use on her own without success beyond 48 hours

Dimension 6 Recovery Environment
Low ☐ Medium ☐ High ☐

Patient lives with recovering people whom she identifies as a source of encouragement. Pt. has been attending self-help groups weekly for the past 6 months and has a sponsor. Pt. states that the sponsor has been advising her to go into residential tx.

Additional comments describing intensity of services:

Patient has been enrolled in NTP for 2 months. She is stabilized on 85mg Methadone and compliant with treatment recommendations. Pt. states that she desires a sober lifestyle. Attempts to stop use on her own have been unsuccessful. Pt. reports two episodes of hallucinations while attempting to obstain from alcohol. Pt. recognizing the need to be compliant with medical recommendations for Hep. C and Bi-polar but states that current lifestyle interferes with her ability/willingness to comply.

Authorized Signature,
Narcotic Treatment Program

_____

Authorized Signature,
Residential/Day Treatment Program

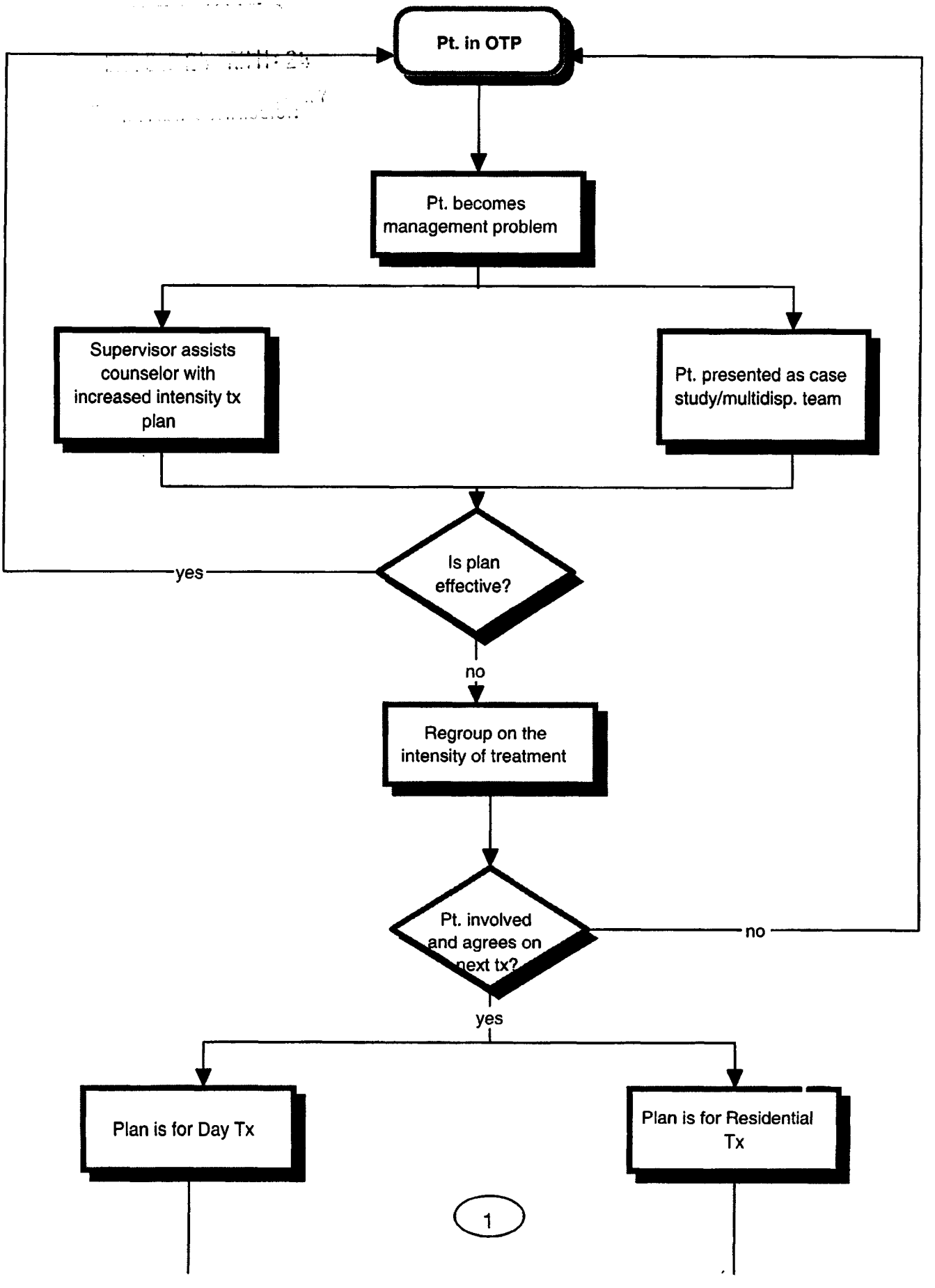
_____

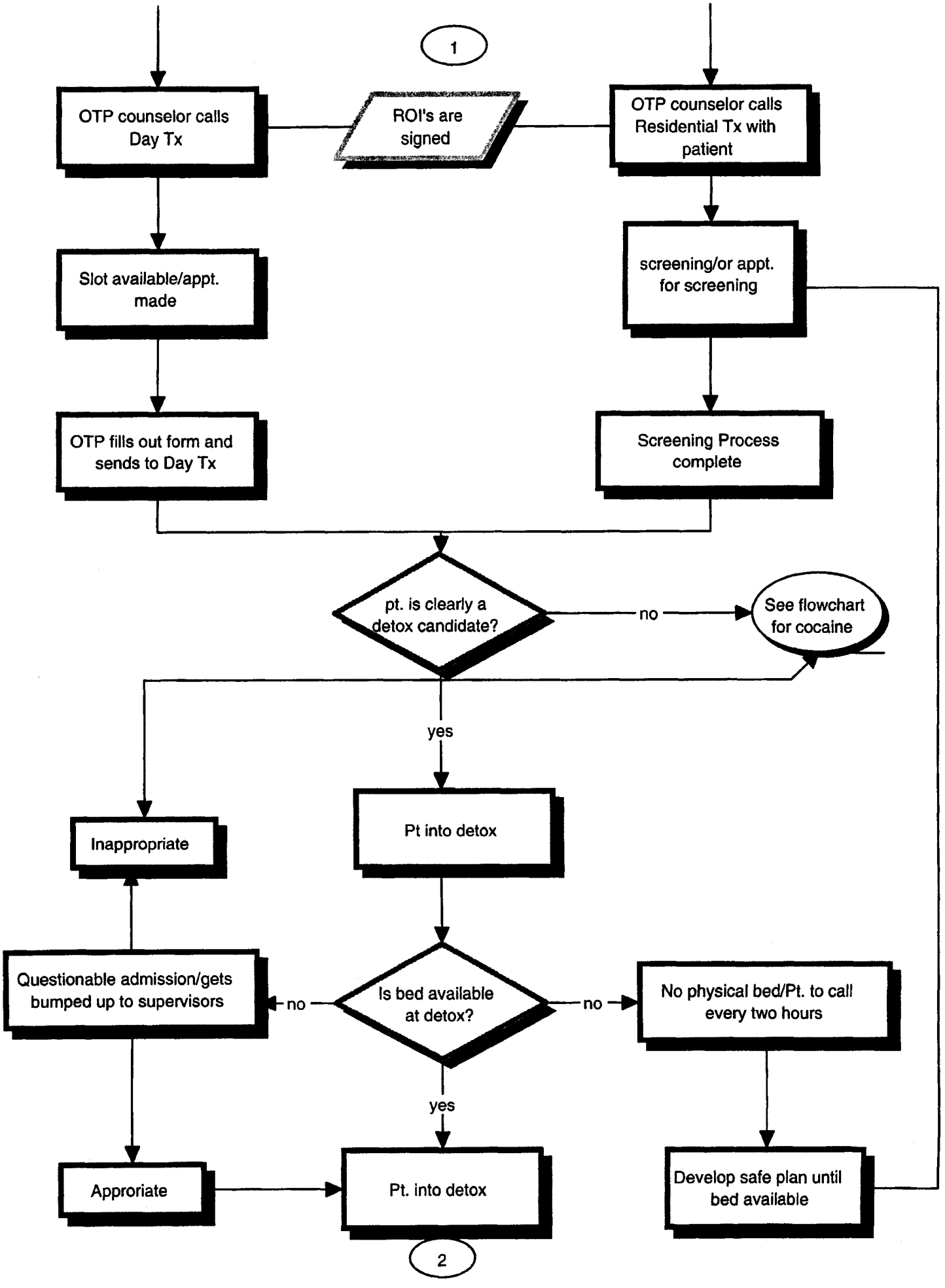
When client is discharged from either applicant programs, the DSA will be notified and approval granted for dual enrollment will expire.

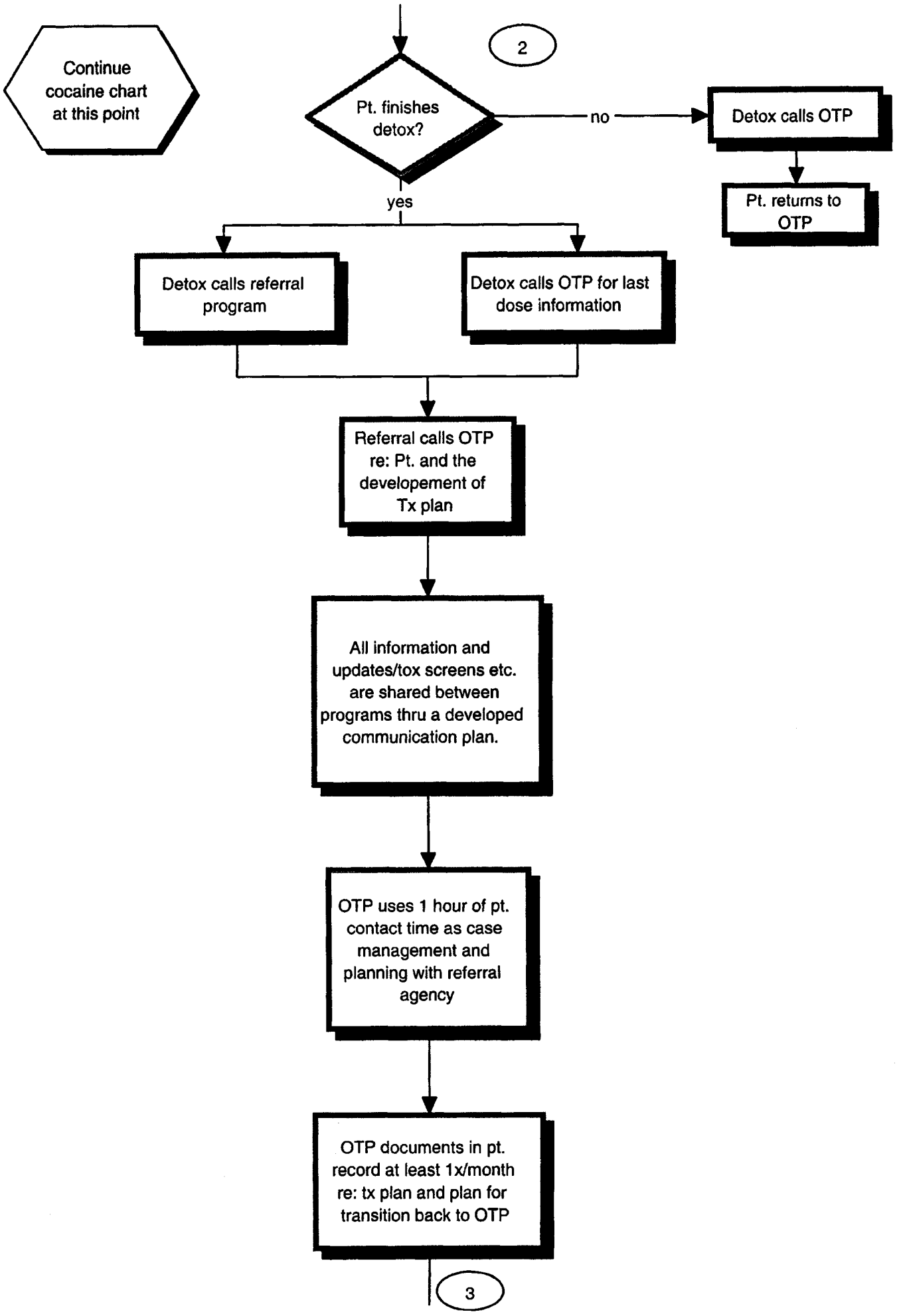
Division of Substance Abuse use only

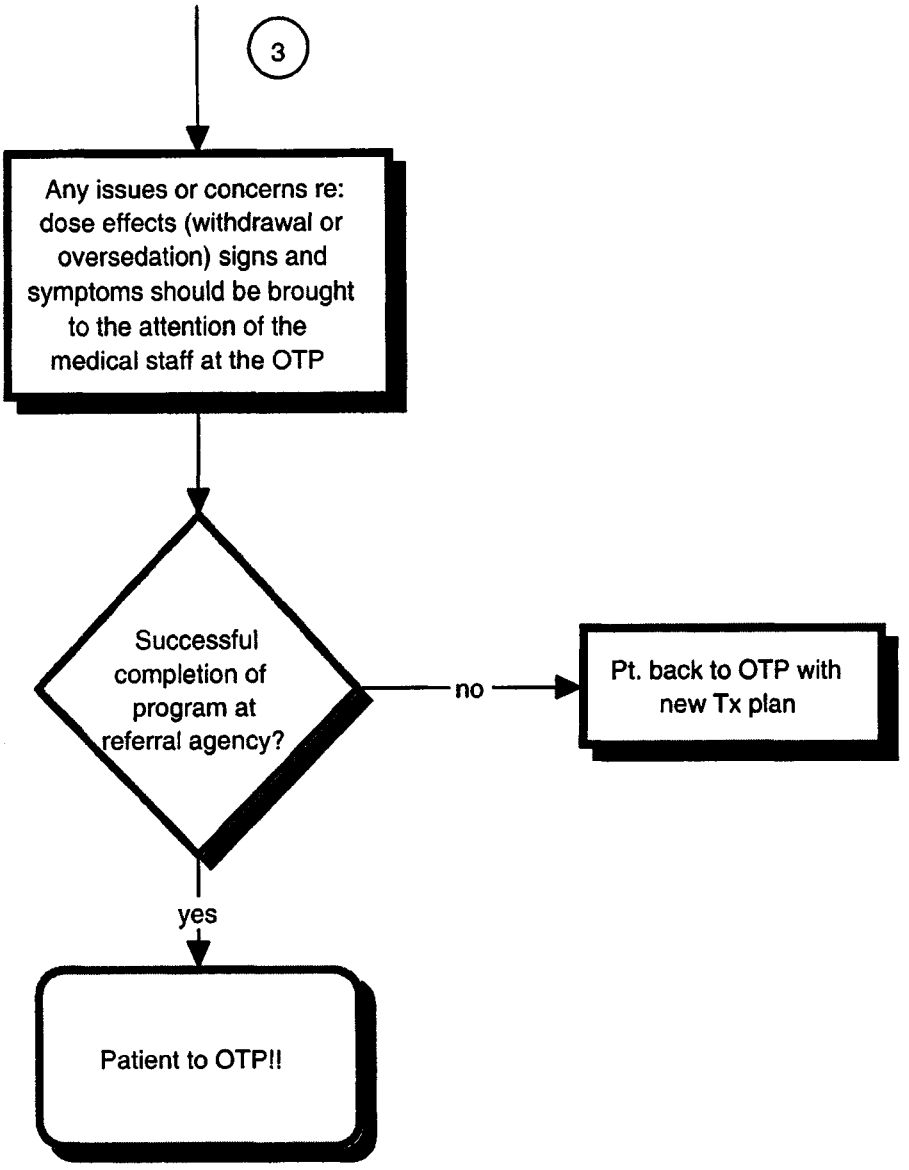
Approval granted/date_____ Approval denied/date_____

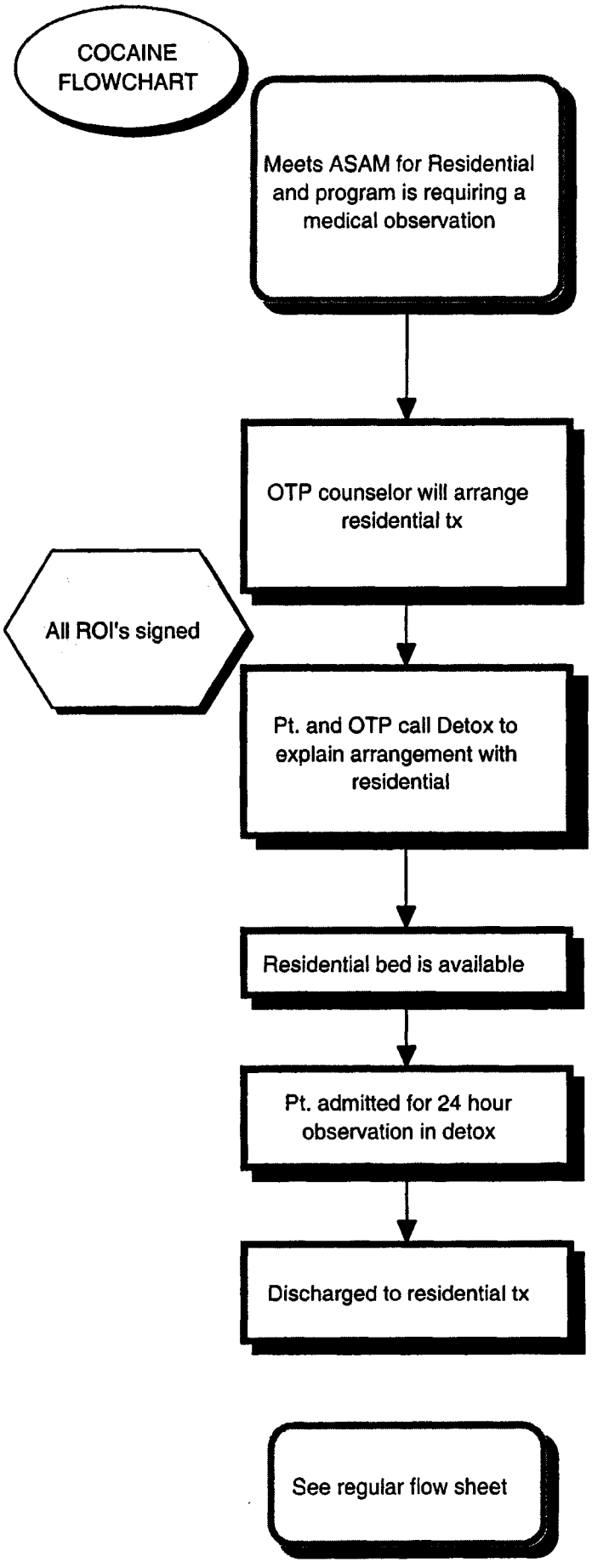
Signature, Chief of Treatment Unit or designee_____


Pt. in OTP
Pt. becomes management problem
Supervisor assists counselor with increased intensity tx plan
Pt. presented as case study/multidisp. team
Is plan effective?
yes
no
Regroup on the intensity of treatment
Pt. involved and agrees on next tx?
no
yes
Plan is for Day Tx
Plan is for Residential Tx
1


1
OTP counselor calls Day Tx
ROI's are signed
OTP counselor calls Residential Tx with patient
Slot available/appt. made
screening/or appt. for screening
OTP fills out form and sends to Day Tx
Screening Process complete
pt. is clearly a detox candidate?
no
See flowchart for cocaine
yes
Inappropriate
Pt into detox
Questionable admission/gets bumped up to supervisors
no
Is bed available at detox?
no
No physical bed/Pt. to call every two hours
yes
Approriate
Pt. into detox
Develop safe plan until bed available
2


Continue cocaine chart at this point
2
Pt. finishes detox?
no
Detox calls OTP
Pt. returns to OTP
yes
Detox calls referral program
Detox calls OTP for last dose information
Referral calls OTP re: Pt. and the developement of Tx plan
All information and updates/tox screens etc. are shared between programs thru a developed communication plan.
OTP uses 1 hour of pt. contact time as case management and planning with referral agency
OTP documents in pt. record at least 1x/month re: tx plan and plan for transition back to OTP
3


3
Any issues or concerns re: dose effects (withdrawal or oversedation) signs and symptoms should be brought to the attention of the medical staff at the OTP
Successful completion of program at referral agency?
no
Pt. back to OTP with new Tx plan
yes
Patient to OTP!!


COCAINE FLOWCHART
Meets ASAM for Residential and program is requiring a medical observation
OTP counselor will arrange residential tx
All ROI's signed
Pt. and OTP call Detox to explain arrangement with residential
Residential bed is available
Pt. admitted for 24 hour observation in detox
Discharged to residential tx
See regular flow sheet

CREATING THE BEST CLIMATE FOR RECOVERY - A WORK IN PROGRESS

The Bucks County Collaborative for Integrated Drug and Alcohol and Mental Health Services

An initiative to address clinical and administrative issues related to service provision for adults with co-occurring disorders

Background.....

- The Center for Mental Health Policy Research (CMHPSR) began working with Bucks, Chester, & Montgomery counties in 1997, on the behavioral health aspects of HealthChoices.
- Project was funded by PEW Charitable Trust
- Initially, provided a series of seminars and individual consultations for MH and SA administrators, staff and managers throughout the 3 counties.

Background.....

- TA sessions gave consumers, family members, providers and advocates a framework for understanding managed behavioral health care principles and technologies.
- Group provided TA focused on the development of skills necessary to build a network of care for individuals with co-occurring disorders.
- In 1999, Delaware County joined the initiative.

Purpose.....

Together, the four counties focused on building a managed behavioral healthcare service delivery model for SE Pennsylvania, *at both the system and provider level.*

The model provided the opportunity for:

- ✳ improved communication
- ✳ cross training of agency staff
- ✳ involvement of consumers and family members in the collaboration process
- ✳ improve treatment and systems outcomes.

Today's situation.....

- There is limited evidence of truly integrated service for individuals with dual diagnosis.
- Diagnosis, and therefore treatment planning, is often driven by the funding mechanism.
- Treatment is compromised.

Vision Statement.....

The Bucks County Behavioral Health System will make available to persons with co-occurring disorders, services that are welcoming, accessible, integrated, continuous, comprehensive, coordinated, flexible, culturally sensitive and disability competent. The services will be available to persons at all levels of care, readiness and motivation will be developed and provided and generally guided by CAASP and CSP principles.

Mission Statement.....

The Collaborative will:

- Promote the education of all system stakeholders as to the needs of individuals with dual disorders and the state of the art interventions that should be available in a comprehensive service system.
- Support the efforts of the County Offices to integrate planning and resource allocation for individuals with co-occurring disorders.

Mission Statement.....

The Collaborative will:

- Enhance communication, coordination, collaboration and the exchange of ideas between mental health and substance abuse service providers.
- Ensure that consumers and recovering persons have a direct and meaningful voice in the development of an integrated system.
- Identify and address gaps in the service continuum and barriers to effective treatment.
- Recommend and advocate for required resources and service development and change.

Member Agencies.....

Lower Bucks Hospital	Bucks Co. Behavioral Health Sys	*Bucks Co. MH/MR*	Bucks Co. Drug & Alcohol Comm.
Matrix Research Institute	*Penndel Mental Health Center*	Lenape Valley Foundation	Penn Foundation
Aldie	*Pro-Act*		*Renewal Center*
Bucks County CST	Libertae	*Reach Out Foundation*	Family Service Association
Magellan Behavioral Health	*CBHNP*	Livengren Foundation	*Today, Inc.*

The Bucks County Initiative……

- Our first meeting was piggy backed with the Consumer and Family Advisory Committee, and was held in April 2000.
- Identified the need for a Clinical Steering Committee, comprised of the Clinical Directors of participating agencies, and consumers and family representatives;

Clinical Steering Committee….

- Meetings are conducted on the second Monday of each month.
- Standing agenda items:
  - Access to Care
  - Barriers to Access
  - Utilization Issues
  - Training Needs

Current Initiatives

- Supporting D & A licensure at the BSU's and acute Psychiatric Units in the County
- Implementing the ***MISA Intensive Support Network II*** through Magellan Behavioral Health
- Development of a model for improving continuity of care, and service enhancement, utilizing the ***MISA Clinical Services Committee***
- Supporting MH licensure for detox and rehabilitation facilities
- Supporting cross licensure for all PH programs

MISA Clinical Services Steering Committee

By Dotti Farr

The Bucks County Behavioral Health System is committed to improving the quality of services received by the residents of Bucks County. To help achieve this goal, the Collaborative for Integrated Drug and Alcohol and Mental Health Services was begun in April of 2000. This initiative, described in the April 2000 ***Commission*** *Connections*, was developed to address the clinical and administrative issues relate to service provision for adults with co-occurring disorders.

The Collaborative meets jointly with the Bucks County Consumer and Family Advisory Committee on a quarterly basis. At the kick-off meeting in April 2000, the need for a Clinical Services Steering committee was identified. This group, composed of county staff, consumers and participating agencies, was formed and meets on the second Monday of each month at 3:00 – 4:30 pm. Barb Voth of Penn Foundation and Dr. Rick Heid of NHS have graciously volunteered to co-chair the committee.

The **Clincial Services Steering Committee** has been meeting on a monthly basis, addressing concerns at both the system and provider level. This model provides an opportunity for improved communication, cross training of agency staff, involvement of consumers and family members in the collaboration process, and improved treatment and systems outcomes.

In addition to representatives from the Bucks County Behavioral Health System (BCBHS), Bucks County CST, Bucks County Department of Mental Health and Mental Retardation (DMH/MR), Bucks County Drug and Alcohol Commission, Inc. (BCDAC, Inc.), Community Behavioral Health of Northern Pennsylvania – Bucks County Office (CBHNP) and Magellan Behavioral Health (MBH), the following Bucks county organizations have joined the committee and verbalized their commitment to improving services:

- Aldie
- Reach Out Foundation
- Penn Foundation
- Lenape Valley Foundation
- Libertae
- Family Service of Bucks County
- Livengren Foundation
- Today, Inc.
- Lower Bucks Hospital
- Northwestern Human Services
- Pro-Act
- Penndel Mental Health Center

If you are interested in participating, or receiving minutes of either the Collaborative or the Clincial Services Steering Committee, please contact Dotti Farr at (215) 773 – 9313. In the event you missed our April 2000 edition, we are again enclosing the Vision and . Mission statement for the Collaborative.

VISION STATEMENT

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MISSION STATEMENT

The Collaborative will:

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- *Ensure that consumers and recovering persons have a direct and meaningful voice in the development of an integrated system*
- *Identify and address gaps in the service continuum and barriers to effective treatment*
- *Recommend and advocate for required resources and service development and change*
- *Promote the education of all system stakeholders as to the needs of individuals with dual disorders and the state of the art interventions that should be available in a comprehensive service system*
- *Support the efforts of the county Offices to integrate planning and resource allocation for individuals with co-occurring disorders.*

/Dotti/Commission Connections March 2001b

The Bucks County Forensic Mental Health Project

The Bucks County Forensic Mental Health Project has as its ultimate goal to increase the number of mentally ill offenders who are successfully reintegrated into the community with a reduction of subsequent recidivism to crime, hospitalization and/or substance use disorders.

Each year we are seeing a continuing escalation of individuals cycling through the Bucks County criminal justice system, and correctional facilities in particular, with a serious mental illness. Exacerbating this problem is a high incidence of co-occurring disorders of serious mental illness and substance abuse and dependency. De-institutionalization of the mentally ill, along with a fragmented system for addressing the complex issues presented by individuals, has impacted these numbers. The Bucks County Department of Corrections has an average in custody population of approximately 900 inmates. About 25 percent, or 225, are actively involved with the Correctional Mental Health Unit; about two to three percent of these offenders are considered to be severely or persistently mentally ill. Our county statistics mirror the national and regional statistics.

The Project, of 18 months duration, was developed initially as a concept in October 2000; the project moved forward through the efforts of the Bucks County Association for Corrections and Rehabilitation, Inc. (BACR) and the Department of Corrections when funding became available through the Pennsylvania Commission on Crime and Delinquency.

The Project creates a Bucks County Panel on Forensic Mental Health Issues

- ***The Panel is looking at problems, issues, and barriers that may inhibit best practices and the successful reintegration of offenders into the community; aims are to foster commitments across systems to develop collaborative long-term strategies to effectively address these problems and to support stakeholders in implementing policies and practices to address barriers***

- ***The Panel has established working groups that will look at major intercepts of the criminal justice system and the mental health system***

1) Law Enforcement and Emergency Services
2) Initial Detention/Initial Hearing
3) Post-Booking Diversion, Jails, Courts, Forensic Evaluations & Forensic Hospitalizations
4) Re-Entry to the Community
5) Community Support Services

Stakeholders include, among others, representatives from the criminal justice system, mental health, drug and alcohol, behavioral health, local government, the community, advocacy groups, consumer groups, religious organizations, and public and private human service agencies.

The Project will sponsor Regional Conference in 2003 on Forensic Mental Health Issues

- ***Highlight Bucks County's efforts to address issues of forensic mental health***
- ***Educate all stakeholders on best practices in forensic mental health***
- ***Provide a forum for discussion of key issues***

BACR
Bucks County Association for Corrections and Rehabilitation, Inc.

The Bucks County Forensic Mental Health Project is funded through a grant from the Pennsylvania Commission on Crime and Delinquency in collaboration with BACR: Bucks County Association for Corrections and Rehabilitation, Inc.

PRO-ACT is a project of the Bucks County Council on Alcoholism and Drug Dependence (The Council), an affiliate of the National Council since 1975. The Council is a non-profit organization that was awarded a federal grant from CSAT to partially fund the PRO-ACT initiative. Through PRO-ACT, The Council will serve as the southeastern Pennsylvania regional coordinator, linking the five counties and the statewide PRO-A, and will develop chapters, offer technical assistance, and organize group activities.

The stigma of addiction that prevents people from seeking treatment must be reduced or eliminated. It is through our services for prevention, education, advocacy, assessment, and intervention that this goal will be accomplished.

CSAT
Center for Substance Abuse Treatment
SAMHSA

Grant No. T1-11641

Produced under a grant funded by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
Center for Substance Abuse Treatment, 5600 Fishers Lane
Rockwall II, Suite 621, Rockville, Maryland 20857, 301.443.5052
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the agency.

Bucks County Council on Alcoholism and Drug Dependence, Inc.
Bailiwick Office Campus • Unit 12
252 W. Swamp Road
Doylestown, Pennsylvania 18901-2444

ADDRESS CORRECTION REQUESTED

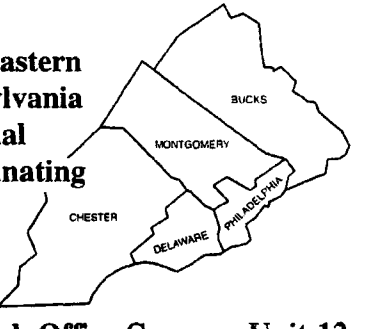
Ambassadors for Recovery

Education-Mobilization-Advocacy

Ambassadors for Recovery

Pennsylvania Recovery Organization Achieving Community Together

Southeastern Pennsylvania Regional Coordinating Office



Bailiwick Office Campus, Unit 12
252 West Swamp Road
Doylestown, PA 18901

(215) 345-6644 • (800) 221-6333
(215) 348-3377 fax

WHAT IS PRO-ACT?

PRO-ACT -- Pennsylvania Recovery Organization - Achieving Community Together -- is a grassroots advocacy initiative founded to promote the rights of and ensure opportunities for those still suffering from the disease of addiction, members of the recovery community, and their family members who wish to advocate, in southeastern Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties).

PRO-ACT is developing and mobilizing a constituency of Ambassadors for Recovery -- recovering persons, their family members and friends, professionals working in the field, and others with a special interest in and knowledge of recovery.

PRO-ACT is dedicated to educating its constituency and mobilizing its members to advocate for the recovery community. The initiative is working to reduce the stigma of addiction, ensure the availability of adequate treatment options, and influence public opinion and policy regarding the value of recovery.

PRO-ACT

Ambassadors for Recovery

WHY SHOULD I JOIN?

During the past 25 years, there has been a shift in public policy from supporting treatment programs for those suffering from addiction to addressing the problem by utilizing the justice system when crimes associated with the disease are committed. This change from proactively treating the illness to recognizing only the criminal ramifications has had a dramatic effect on public opinion towards the disease of addiction and recovery, dramatically increasing stigma and reducing opportunities for all those affected. In recent years, discrimination against addicts and those in recovery by insurance companies, corporate America, the media, and others has gone largely unchallenged. PRO-ACT has been founded to be a voice for advocacy and change.

MEMBERSHIP

PRO-ACT encourages members of the recovery community, family members and friends, treatment providers, counselors, nurses, and others interested in education, mobilization, and advocacy to join this initiative. Annual membership includes membership in PRO-A, the statewide initiative, subscription to a monthly newsletter, and advance notice and priority registration for special events.

Please fill out and mail in the membership form at the right or contact the PRO-ACT office at The Council at (215) 345-6644 for more information.

Please detach here

MEMBERSHIP FORM

Name _____

Address _____

City _____ State _____ Zip _____

County of residence _____

Home phone _____ Work phone _____

E-mail _____ Fax _____

The following information is optional and will be used confidentially for statistical reporting only.

Are you: Recovering? _____ If so, how long? _____

Family member? _____ Friend? _____

Service provider? _____

Gender _____ Age _____ Race _____

Individual/family membership dues are $20 per year, which includes membership in the statewide program PRO-A. If you are unable to pay the membership dues please contribute what you can. We will also accept contributions greater than the amount of membership to assist those who cannot afford the yearly fee. No one will be denied membership because of their inability to pay.

Individual/family membership $20 _____

Organizational membership $100 _____

Contribution _____

TOTAL _____

For additional information, please call The Council at (215) 345-6644 and ask for PRO-ACT.

Make checks payable to BCCADD and mail to:

PRO-ACT

Bailiwick Office Campus, Unit 12, 252 W. Swamp Road

Doylestown, Pennsylvania 18901-2444

Premises of Reach Out:

- Consumers of Behavioral Health Services must take a leadership role in improving services;
- Consumers of Behavioral Health Services must take responsibility for their own wellness;
- Consumers of Behavioral Health Services help themselves by helping others.

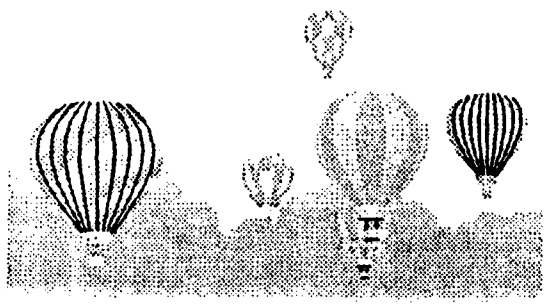
Behavioral Health Consumers striving to give each other, and all persons, respect.

For More Information
about any of our services, call:

215 428-0404

Fax 215 428-2835

Reach Out Foundation
Pennsbury Plaza
229 Plaza Blvd., Suite 101
Morrisville, PA 19067



Consumer Board Members

Kathy Sharp, Levittown, President
Debbie Atkinson, Bensalem
Steven Hasher, Croydon
Bryan Hutchinson, Levittown
Donald Merrick, Yardley
James Marcellus, Levittown
Mark Morgan, Levittown
Geraldine Mulligan, Croydon

Professional Advisory Board

Christopher Bursk, Professor,
Bucks County Community College, Newtown

Brian Cohen, Business Advisor

Ann Kime, BS, Member of AMI, Yardley

Timothy Kolman, Esq.,
Kolman & Associates, Langhorne

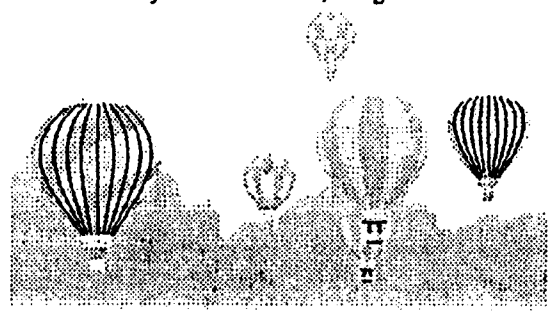
Ronald Langberg, Ph.D., Psychologist, Bristol

David Nover, MD, Psychiatrist, Doylestown

John Page, AAC II,
Bucks Co. Council on Alcoholism & Drug Dependence

Sam Samat, MBA, Chief Operating Officer,
Handisoft, Inc., Philadelphia.

Nancy Scheible, MA, Mental Health Counselor,
Delaware Valley Medical Center, Langhorne



REACH OUT FOUNDATION

OF BUCKS COUNTY

Respect

Education

Advocacy

Community

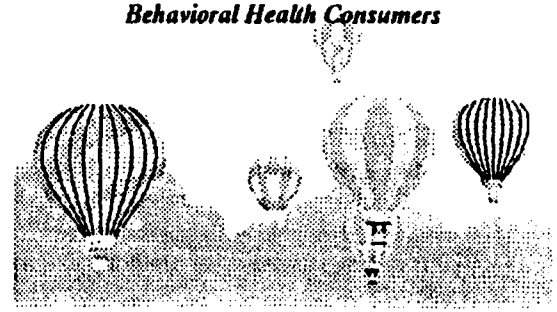
Health

One

United

Team

Behavioral Health Consumers Helping Behavioral Health Consumers



Our Mission:

To empower Consumers of Behavioral Health Services, and to help them speak out for themselves and others.

Current Services

Formal and Informal Education Programs about Behavioral Health Issues

Bright Perspectives of Levittown Support Group

Bright Perspectives of Bucks County Community College Support Group

Double Trouble Support Group

Open Minds Young Adult Support Group

Individual Advocacy

Political Advocacy

Employment Support

Consumer Support

Mental Health Service Publications

Where Did Reach Out Come From?

Reach Out was founded in 1995 by members of three organizations: the Bucks County Bi-Polar Advocacy Committee, the Lower Bucks Social Club and New Directions of Levittown Support Group.

Why Reach Out?

Reach Out is managed entirely by Consumers of Behavioral Health Services. Our experienced and dedicated staff provides leadership and support for all Consumers on a wide variety of issues. We are always seeking out and utilizing the most current and proven techniques integrated with the best available advice and personal experiences to accomplish our objectives and provide the highest level of service.

About the Foundation:

Reach Out Foundation of Bucks County is a non-profit corporation consisting of nine board members who are themselves consumers of Behavioral Health Services and who have been active in all facets of advocacy and recovery for many years.

Additionally, *Reach Out* has selected an Advisory Board of community leaders to provide expertise and support.

Our group was launched with the help of a Federal grant from Bristol Township. We encourage funding and donations from other sources at any time.

About *Bright Perspectives:*

Bright Perspectives is a support group for people with Depression or Bipolar Disorder. The groups meet to provide friendship, support and information in a confidential, positive, nonprofessional environment.

About Double Trouble:

Double Trouble is a Twelve Step Self-help group for people with a dual diagnosis of mental illness and substance abuse/addiction. Our primary purpose is to maintain our mental or emotional wellbeing. People are invited to join and begin or continue their mental, physical and spiritual recovery.

Reach Out Foundation of Bucks County
is a Non-Profit Corporation
Chartered under the Laws of The Commonwealth of Pennsylvania
Federal Tax ID# 23-2845647

About Open Minds:

Open Minds is a support group for young adults. The meeting is geared towards individuals in the vulnerable 18-25 age bracket. Discussions revolve around the unique challenges they face in managing substance abuse/addiction, mental health issues and the difficulties of day-to-day living. ***"Whatever ails ya, bring it to the table".***

About Advocacy:

Reach Out provides individuals with confidential non-professional support to identify and receive public and private services. Individuals are advised of available resources. Assistance is available to help Consumers access or retain vital or fundamental services or funding needed to sustain or improve the quality of life.

About Political Advocacy:

Reach Out Board Members frequently meet with and correspond with local and state officials in order to gain support on a variety of Behavioral Health issues including, but not limited to, Mental Health Parity, affordable housing and transportation and needed medical services such as Crisis Intervention and Aftercare.

About Employment:

Hopefully, with community and financial support, *Reach Out* will add this much needed service in early 1999.

ROF

Reach Out Foundation of Bucks County

229 Plaza Blvd. ~ Suite 101 ~ Morrisville, Pennsylvania 19067
Phone 215-428-0404 ~ Fax 215-428-2835
Email reachout.foundation@worldnet.att.net

SUPPORT GROUPS

Bright Perspectives @ Bucks County Community College,
12.30 p.m. –1.30 p.m. Every Monday.
(Depression and Manic Depression and other mood disorders)

Employment Group @ Reach out Office, 3:30– 4:30 p.m.
Every 2nd & 4th Monday.
(Employment Support)

Double Trouble @ Reach Out Office, 2.00 – 3.00 p.m. Every Wednesday.
(Dual Diagnosis – Mental Health and Substance Abuse Issues)

Day to Day @ Reach Out Office, 6.00 – 8.00 p.m. Every Wednesday.
(Peer- to- Peer Support)

Bright Perspectives @ Christ Evangelic Lutheran Church,
7.30 – 9.00 p.m. Every 2nd & 4th Wednesday.
(Depression and Manic Depression and other mood disorders)

Double Trouble @ Reach Out Office, 7.00 – 8.00 p.m. Every Thursday.
(Dual Diagnosis – Mental Health and Substance Abuse Issues)

Open Minds @ Reach Out Office, 7.00 – 8.00 p.m. Every Friday
(Open forum for young adult issues)

Join us at the Reach Out Foundation Weekend Drop-In Center At Penndel Mental Health Centers' "Rainbow House" Drop-in Center 1272 New Rodgers Rd., Bristol, PA 19007 Saturday's & Sunday's From 3:00–7:00 p.m. SEE YOU THERE!!

WHERE DO WE GO FROM HERE? THE CHALLENGE FOR TREATMENT PROFESSIONALS

Treating Patients

How does it all fit together?

Peter A. DeMaria, Jr., M.D., FASAM
Division of Substance Abuse Programs
Department of Psychiatry & Human Behavior
Jefferson Medical College
Philadelphia, Pennsylvania

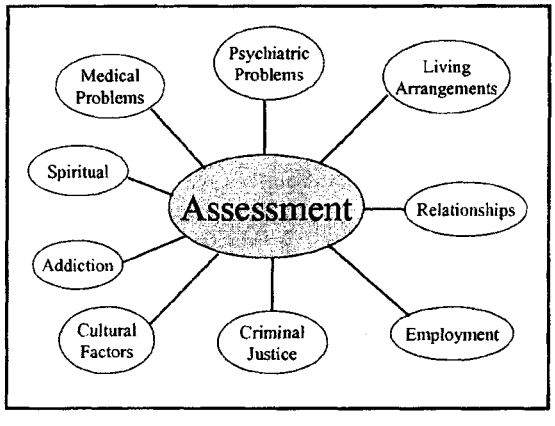
TREATMENT

DIAGNOSIS

Problem List

ASSESSMENT

Evaluation



Case Study

Susan is a 46 y/o divorced woman who presents to an assessment center stating she is depressed and suicidal. She states she has relapsed to heroin use after being discharged from a detox program a month ago. She has been drinking up to a fifth of vodka per day and taking Xanax to help her with opiate withdrawal symptoms. You learn she is HCV (+) and is on parole for shoplifting charges. Her PO has told her if she gives another (+) UDS she will go to jail. She lives with her abusive alcoholic boyfriend.

A Comparison of Pharmacotherapies

	Heroin	Methadone	Insulin
Produces a 'high'	Yes	No	No
Prescribed by a physician	No	Yes	Yes
Underlying disease potentially fatal	Yes	Yes	Yes
Improves quality of life	No	Yes	Yes
Counseling necessary	No	Yes	Yes
Decreases complications of underlying disease	No	Yes	Yes
Lifetime use	Maybe	Maybe	Yes
Use potentially fatal	Yes	No	No

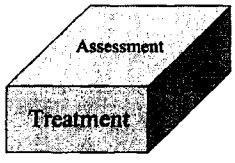
Case Study, 6 months later

Susan was admitted to MMT. She has stopped her heroin use but continues to take Xanax and drink alcohol to treat her anxiety. She continues to live with her abusive alcoholic boyfriend. She is unemployed and supports herself with welfare. She grew up in an abusive addicted family and was sexually abused by a family friend. She just learned that her 19 year old son has started snorting heroin.

Summary

- Assess each patient individually
- Develop an individualized treatment plan (not all things work for everyone)
- Have a variety of settings and modalities available.
- Match patients with treatment
- Monitor patient's response to treatment
- Change treatment plan as necessary

Can you think



outside of the box?

Treating Patients

How does it all fit together?

Peter A. DeMaria, Jr., M.D., FASAM
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Jefferson Medical College
Philadelphia, Pennsylvania

TREATMENT

DIAGNOSIS

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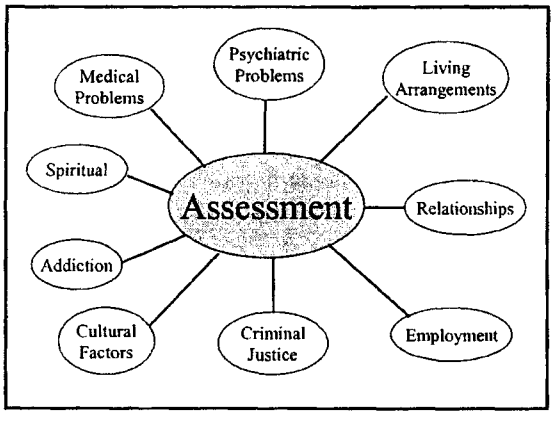

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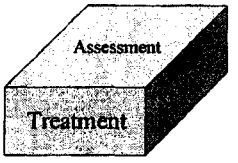


Outside of the box?

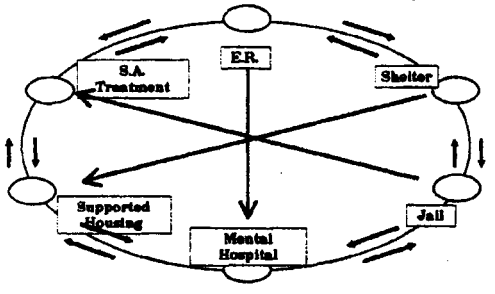
SAMHSA-CSAT-
Bucks County PA D&A
Commission

CO-occurring Perspectives
Bert Pepper, MD
9/10/02

My 25 years with
co-occurring disorders

Lessons learned

From Crisis to Recovery to Relapse



Perspective #1:

Trauma, emotional disorders, and substance abuse:

Understanding the vicious cycle

A Common Sequence–
From troubled child to adolescent in trouble

1. Trauma (physical, sexual, psychological, emotional) or neglect in childhood
2. Early emotional problems
3. Personality immaturity or disorder
4. Self-medication- AOD
5. School & family problems
6. More severe psychiatric problems
7. Criminal justice involvement

A Section on

Epidemiology and Genetics

A subtle trauma-Maternal smoking during pregnancy has long term negative effects on children

Marked gender differences–If a woman smokes 10 or more cigarettes/day during pregnancy–

- Her daughters risk for adolescent drug abuse is increases by more than 500%–
- Sons risk of conduct disorder increases by more than 400%
- An association has been found between prenatal smoking and ADHD.

Genetics of Alcohol Dependence

- Genetic factors account for 40–60% of risk; remainder is social–environmental
- No single gene controls
- Adoption studies strongly indicate a genetic factor among males: Risk is 2.6 times greater for boys with a family history
- 5 of 5 studies of boys agree
- Situation less clear for girls, but higher risk probable

ECA Lifetime Prevalence Rates For Substance Abuse Among Persons With Affective Disorders: Regier 1988

	Bipolar %	Major Depression %
Alcohol Abuse or Dependence	46	17
Abuse Only	15	5
Dependence	31	12
Drug Abuse or Dependence	41	18
Abuse Only	13	7
Dependence	28	11
Any Substance or Dependence	61	27

National Co-morbidity Survey-1990- Ron Kessler

- Stratified sample of U.S. population
- 8, 000 individuals interviewed, 15-55
- CIDI, modified, WHO approved, used
- All positives were re-interviewed
- The gold standard of epi studies of MH-SA
- Replicated and expanded in 2000-2001
- New data due in 2003: U.S. and world

National Co-morbidity Survey-1990- Kessler, p. 2

- 48% of respondents reported at least one **lifetime** disorder; 29.5% reported at least one in the **past year.**
- **Major depressive episode**: 10.1% – episode in the past year. 17% lifetime. Women > men.
- Lifetime **alcohol abuse** – 14.1%. Past year–7.2% Men > women
- Lifetime, at least one **anxiety disorder**–24.9%
- Past year–17.2%. Simple and social phobias were commonest.

Source: February, 1994 Kessler, et al. in Archives of General Psychiatry

NCS -P.3

- 79% of all lifetime disorders occurred among persons reporting two or more disorders
- 14% of respondents had 3 or more lifetime disorders. They collected:
  - 53.9% of all lifetime disorders,
  - 58.9% of all past year disorders, and
  - **89.5%** of all past year severe disorders

Source: February, 1994 Kessler, et al. in Archives of General Psychiatry

NCS – P. 4

- **8-11** million have at least 1 mental health and 1 substance-related disorder
- 89% developed mental illness first-
- 9% developed substance abuse first
  - **Median age of onset:**
  - **Mental Illness - 11**
  - **Substance Abuse - 17-21**

Source: February, 1994 Kessler, et al. in Archives of General Psychiatry

NCS – P. 5

The take home message:

- No disorder– great!
- One disorder– stay in treatment and recovery and have a life
- Two disorders– hard to keep life going on an even keel
- Three+disorders– high likelihood of being disabled, unemployed, and labeled SMI

A section on

Personality: Disorders

or

Immaturities?

Robert's case

Sir William Osler

- Sometimes it is more important to know what kind of a person has an illness,
- Than what kind of an illness a person has.

Personality defined

The stable, predictable patterns of

- **Feeling**
- **Thinking, and**
- **Behaving**

– that define a person uniquely to self, and to others.

- Because they have developed gradually since birth, these personality traits are **ego-syntonic**– i.e. feel normal, in harmony with one's sense of **self.**

Personality disorders

- Stable, predictable patterns of feeling, thinking, and behaving that **bother other people**
- Also called character disorders or character neuroses
- Because they develop early, these traits are **ego-syntonic**
- There are 10 different PDs on Axis II, DSM–IV. They overlap. Many experts write: 'Personality Disorder, N.O.S.

3x

Personality Immaturities

(Pepper)

Patterns of feeling, thinking and behaving that:

- Are fairly stable, but
- May change in response to social stimuli or opportunities for growth.
- May be ego–syntonic or ego–dystonic

Consider: ASP and BPD

Treatment in a Therapeutic Community

- Special T.C., opened in 1988 in The Bronx

  Only admitted homeless, crack etc. addicts with SMI, multiple hospitalizations

- Up to 18 months L.O.S.

- Aggregated funding

T.C. Intake Case Conference – Robert –

- 22 y.o single black male.

- Entered a Therapeutic Community for dually diagnosed homeless men, from a shelter.

Robert was adopted at age 3, by a reluctant aunt

- Mother an addict.

- Multiply abused and neglected child.

T.C. Intake Case Conference – Robert –more history P. 2

- Charged at age 8, with others, with molesting a little girl.

- Jailed at 19 for rape.

- Bitter about having been raped in prison.

- Only heterosexual contacts were with prostitutes

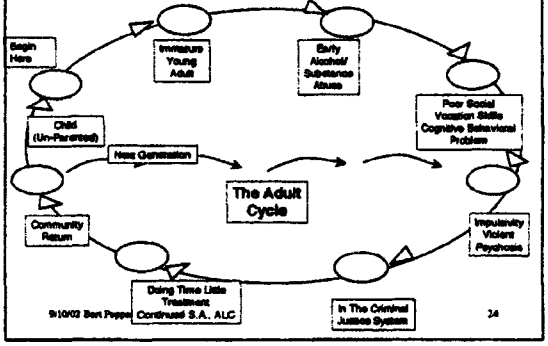
T.C. Intake Case Conference – Robert – P. 3

- Obtained money for drugs by prostitution.
- Sexual identity an issue.
- 3 psychiatric hospitalizations

Diagnosis on admission:

1. Paranoid schizophrenia, chronic
2. Antisocial personality disorder
3. Poly –substance abuse: crack, pot, alcohol

The Life Cycle



Styles of Infant and Adult Attachment in response to distress –

(Bowlby, Ainsworth,Main. Dozier, others)

1. **Secure**
2. **Anxious**
3. **Rejecting–avoidant–**
4. **hostile**
5. **Dependent**
6. **Disorganized**

What is the style of the attention–seeking help rejecter?

Personality v. Character

Both derive from Greek roots:

Character: Etched in stone, cannot be erased (changed).

Personality: An oversized mask carried by an actor on stage, to tell the audience how s/he feels. Can be switched for another mask.

Ten Common Personality Immaturities (Pepper)

1. Low **frustration** tolerance
2. Can't work persistently for a **deferred goal**
3. **Lying** to avoid punishment, guilt
4. Conflict between **autonomy** and **dependency**, resulting in **hostile dependency**

Ten Common Personality Immaturities P. 2

5. **Limit** testing
6. **Dualistic,** not contextual.
   Judgments are all or none. No moderation
7. **Present** tense only; behavior not based on past or future
8. **Denial:**
   a. Of unpleasant but necessary duties
   b. Time to stop playing, having fun

Ten Common Personality Immaturities, P.3

9. **Rejection sensitive:**
   a. Can't say no
   b. Seeks approval by promising too much
10. **Alexithymia**

Alexithymia P. 2

- May cause the person to express emotions by **behaviors,** while unaware of their emotional cause
- Interferes with self-soothing
- Makes it difficult to ask for help

Robert – 11 months later

1. **Asking Curtis, "Can I make it?" (secure attachment style)**
2. **Tiling the bathroom for 2 hours (improved frustration tolerance: persistence toward a goal)**
3. **After failing probe, requesting to be re-scheduled (limit testing, rejection sensitivity)**

Robert, 11 months later P. 2

4. **Personing 'the booth' (low rejection sensitivity)**
5. **Asking for help with sexual issues: (Less alexithymic, feelings verbalized)**
6. **$6,000 in the bank and staying put (future tense)**
7. **Diagnosis changed to PTSD++**

Pepper's List of Mature Personality Characteristics

1. Can delay gratification
2. Can express feelings, thoughts, wants and needs
3. Can hear feelings and thoughts of others
4. Can negotiate for wants & mediate between others

Pepper's List of Mature Personality Characteristics– 2

5. Can trust others when warranted
6. Can soothe self
7. Can accept criticism without excess shame or guilt
8. Can use thoughts to control negative affects; thus over-riding impulsivity

Pepper's List of Mature Personality Characteristics–3

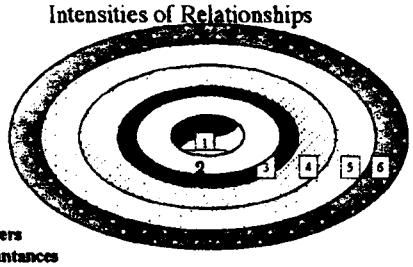
9. Can put down 2 apples to pick up a big, beautiful toy
10. Can play when it is safe, but switch quickly to adult when endangered
11. Can learn from the experience of others
12. Can change when change is seen as necessary, before forced to.

Social Skills–

Alternatives To Violence

- **can express a complaint**
- **enjoys helping others**
- **is able to mediate**
- **can make a request**
- **can listen empathically**
- **can identify own, others feelings**
- **has empathy for others**
- **can deal with failure**
- **can express affection**
- **responding to other's feelings**
- **has developed refusal skills**
- **dealing with an accusation**

A Sociogram:
Intensities of Relationships



6. Strangers
5. Acquaintances
4. Casual friends
3. Good friends
2. Circle of intimacy: trusted intimates
1. [illegible]

What about using meds in a modified TC?

- 100% of residents were admitted on meds
- 70% were on meds at graduation
- Klonopin was used selectively; no problem
- Could we have used methadone?

A case:

Maury, 19

A little about Maury, 19

- 6 felony charges, including arson
- Short, thin, fast talking top salesman- electronics.
- Wealthy, divorced family, oldest of 3
- ADHD, LD, high school drop out; has GED
- Pot daily since age 11; all drugs used + alcohol
- Looked at list of Immaturities, sees himself as 8–10 years old
- Likes helping people; remorseful, yet...
- Meets criteria for ASP

A section on The rights of children and adolescents

The changing experience of childhood in the U.S. today

The Basic Needs and Rights of All Children

1. adequate food
2. protection from harm
3. security
4. affection
5. physical contact
6. physiological stimulation
7. play
8. intellectual stimulation
9. peer group activity
10. learning by example
11. support in developing an identity
12. hope for the future
13. approval

Comparing the State of Children
1960 and 1990

1960		1990
5%	Children born to unmarried mothers	28%
7%	Children under 3 living with one parent	27%
2%	Children under 3 living with divorced parent	4%
<1%	Children under 18 experiencing the divorce of their parents	50%
17%	Mothers return to work within one year of a child's birth	55%
18.6%	Married women with children under 6 years old in labor force	60%

Individuals Living as Couples Without Being Married:

- 1970–one million
- 1997-eight million

Step-parents are likelier to abuse children than biological parents, and

Unmarried couples are less likely to stay together

A section on

Children with parents in jail and prison

Two Strong Predictors of Future Childhood Arrest

1. Incarceration of a Parent
2. Neglect or abuse

A Causative Factor– Childhood Arrest

- The Child Welfare League studied 75,000 children, age 12, in Sacramento County, CA.

1. 1,026 had been identified as abused or neglected.
2. 50% of them had an arrest record.

Prison Stats

Source: U.S. Bureau of Justice Statistics, August 2000

- The number of children with parents in prison >
- From 936,500 in 1991 to 1.5 million in 1999
- Fathers – 1,372,200: •Mothers – 126,100 (rose 98%)
- In 1999, 56% of prisoners had a child, 58% under 10
- 44% were in state prisons for violent crimes
- 67% were in federal prison on drug charges
- The average parents sentence is 6.5 years in state prisons, 8.5 in federal.

Prison Stats P. 2

- The average parents sentence is 6.5 years in state prisons, 8.5 in federal prison.
- More parent prisoners used drugs prior to incarceration than non-parents.
- 33% of mothers committed crimes for drugs.
- Before prison less than half of parents lived with their kids
- 57% of fathers, 54% of mothers were never visited by their children while in prison
- Most children lived with relatives

Child sexual abuse in the TC population

- 100% of the women had been prostitutes to support their drug habit; had been sexually abused in childhood. Many met PTSD criteria.
- 70% of the men had been sexually abused as boys

Child sexual abuse (CSA) & subsequent psychopathology

Molnar, et al. AJPH 2001; 91:753-60

- CSA reported by 13.5% of women, 2.5% of men
  - Under-reporting is probable
- Among women: Rape, known perpetrator, and duration of CSA increased odds of disorders
- CSA usually occurs with other adversities

Child sexual abuse & subsequent psychopathology P. 2

- But even with no other adversities, CSA increased odds of S.A. and depression
- Alone or in a cluster, CSA substantially increased risk of subsequent psychopathology
- Molnar, et al, AJPH 2001; 91:753-60

Child sexual abuse & subsequent psychopathology P. 3

Controlling for other adversities, CSA was associated with:

- Significant associations with 14 mood, anxiety, and substance abuse disorders in women,and
- Significant associations with 5 mood, anxiety, and substance abuse disorders in men

Abuse and neglect vary in nature, cause, and consequences

- Not all trauma is willful or intentional
- Neglect can be as damaging as abuse
- Emotional or physical abuse can be very harmful
- Illness or death of a parent or sibling can cause the effective loss of both parents for the surviving kid(s)
- Poverty is traumatic
- Racism is traumatic
- Bullying is traumatic

The essence of PTSD

- 8-9% of the population suffers from PTSD
- It is commoner in women than men
- Complex psycho-biology: Receptors disturbed:
  - Adrenaline,
  - serotonin,
  - opiate,
  - glutamine
  - other neuro-endocrine pathways

PTSD P. 2

Many factors influence risk of PTSD:

- Age;
- Type of trauma- human or natural;
- Severity;
- Duration;
- **Prior trauma**
- Individual factors
- Gender
- Pre-existing anxiety, depression, etc.

PTSD P. 3

Three important symptom clusters:

1. **Intrusive re-experiencing**; flashbulb-flashbacks, nightmares, anticipatory anxiety/panic
2. **Avoidance & numbing**; alexithymia; reduced response to the world
2. **Hyper-arousal**: sleep disturbance; exaggerated startle; irritability; anger; anxiety/panic

PTSD P. 4

Medications: Review by Hagaman, et. al.
Acta Psychiatrica Scand. 2001:104: 411-22

1. SSRI's are medications of choice; they help all 3 symptom clusters
2. Tricyclics are next; Little effect on avoidance & numbing, but help anxiety and depression
3. MAOI's may be better than tricyclics, but riskier

PTSD P. 5

Medications: Review by Hagaman, et. al.

4. Avoid benzodiazepines if at all possible
5. Beta-blockers (propanolol) can help physical symptoms of anxiety, but can worsen depression
6. Nefazodone (Serzone) can help, but there are liver risks
7. Wellbutrin may help occasionally, may worsen symptoms

PTSD P.5 Treatment Guidelines from the International Consensus Group on Depression and Anxiety

- Cognitive-behavioral tx (CBT) for mild PTSD
- CBT + meds for moderate & severe PTSD
- More study is needed of combined tx

PTSD P 6

Expert Consensus Guidelines

Recommended:

- Anxiety management
- Cognitive therapy
- Exposure therapy (Edna Foa)
- Play therapy for children
- Psycho-education (what is a panic attack; the locus ceruleus; etc.)

PTSD P. 7

Expert Consensus Guidelines, cont'd

Not recommended:

- EMDR (But Foa and Pepper disagree)
- Hypnotherapy
- Psychodynamic psychotherapy

In Conclusion

- Trauma & PTSD may be a key link between MH & SA problems
- There is a prevention window of opportunity with kids:
  - Keep them safe
  - Treat their MH problems promptly, to prevent SA
- Sub-diagnostic PTSD may contribute greatly to co-occurring disorders
- Such individuals have low self-esteem, trouble with intimacy, and for them
- Alcohol & drugs are their best friends

What adolescents in residential SA Tx say:*

Once I was sent to inpatient,

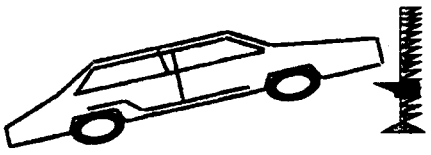
- No one asked my opinion about my treatment
- My mental health & emotional problems were ignored
- My family was left out of my treatment
- **But I had emotional problems before I had a drug problem.**

*Ten focus groups, 110 adolescents recently in residential SA TX. Federation of Families

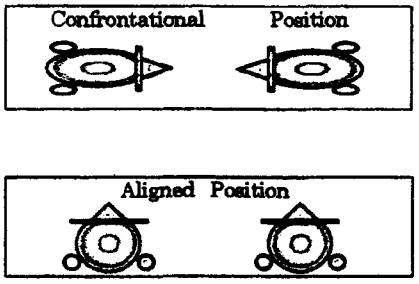
Four Step Assertiveness Technique

1. Repeat the offending statement
2. Say, "This makes me feel...
3. "I wish you'd say...."
4. But if you continue....then I will have to....

Reframing–
One notch at a time



There are no dead end jobs,
only entry level jobs



Treatment Programs for Adolescents & Young Adults

1. Integrated treatment
2. Bio-psycho-social assessment
3. Crisis resolution– stabilization
4. Age separated from older adults
5. Flexible, non-stigmatizing, informal day/evening programs

Treatment Programs for Adolescents &Young Adults Pt 2

6. Rehabilitation – social and vocational – of functional disabilities
7. Realistic goal setting: "Up A Notch"
8. Self–awareness training: "Self Signal Sensitization"
9. Involve family: support, inform, involve

Adolescents in residential SA Tx said:*

Once I was sent to inpatient,

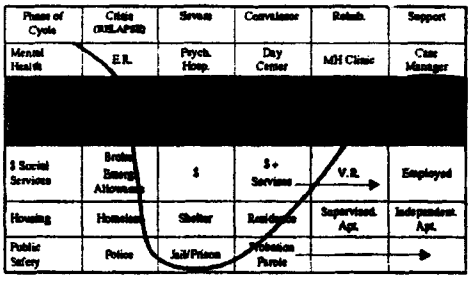
- No one asked my opinion about my treatment
- My mental health & emotional problems were ignored
- My family was left out of my treatment
- **But I had emotional problems before I had a drug problem.**

*Ten focus groups, 110 adolescents recently in residential SA TX. Federation of Families…

Double Trouble Recovery aids medication compliance

- One year follow up of 240 members of DRT groups
- Regular attendance correlated with 79% adherence to prescribed meds; upper end of compliance studies
- Fewer psych hospitalizations
- 12 step groups don't usually support compliance, but they can, and some do; e.g., DTR
- Magura, et al. Psychiatric Services, 3/02

Vertical & Horizontal Service Integration



Edna Foa, PhD: In vivo and imaginal exposure

- New, well-researched Tx for chronic PTSD; 30 days to 30 years. U. Penn Dept.Psychiatry, Anxiety Disorders Clinic
- Ten sessions, 90 min., in 5 weeks, with daily homework
- Used mainly with women who were raped
- Not yet studied in adolescents

EMDR: Francine Shapiro, PhD

- Uses rapid alternating left-right stimuli: visual or tactile
- Elaborate technique, carefully described and researched. Requires training
- Patient keeps trauma picture in mind during stimulation, is encouraged to let picture move, change
- Is more of an adjunct to psychotherapy than a complete treatment

Similarities between Exposure and EMDR

- Both may be traumatic, involve re-exposure to trauma memories
- Both hold the patient in the past and the present simultaneously
- Foa believes eye movements add nothing, but states that EMDR works

Eleanor started her recovery at 73

- First Tx @ 73, to prepare to retire and move
- Told me of abuse by uncle, 8-10
- "I never forgot. It affected every aspect of my life."
- Safe, affectionate but loveless marriage
- Physically distant from her children

A definition of <u>Integrated Treatment</u> (I.T.)

The design and provision of **a long-term, time phased sequence** of different techniques and approaches

- Titrated in intensity
- That respond to the multiple, changing symptoms and disorders of the patient.

I.T. may be provided by one clinician,or by a cross-trained team

Treatment Planning:

Pepper's three stage approach

•The three stage model of treatment planning

- Stage One:
- 4–10 sessions

• Crisis stabilization

Stabilization and crisis resolution

Warm, accurate empathy from the first phone call

Offer your secure attachment style

Focus on the crisis or other reason for referral, but footnote other issues for later reference

Don't prescribe meds on first visit unless absolutely necessary

Stabilization and crisis resolution, p.2

Contract for 3–6 sessions

See relative(s) to:

- Gather information,
- Mobilize support
- Assess attachment style (e.g., does refusal reflect shame or paranoia?)

Empower, by offering to terminate or move on to Stage Two

The three stage model of treatment planning
Stage II

• Troubling issues & Quality of life

The three stage model of treatment planning

- Stage III A:
  - •Ongoing support, often with meds
- Stage III B:
  - •Depth work

The Triune Brain

–Paul McLean

- All mammals born dependent, only able to suck and cry:
  - –The Distress Cry, and later
  - –The Separation Cry
  - ••••••••••••••••••••••
  - Brain I: The snake brain-autopilot
  - Brain II: The limbic system– the emotional brain– timeless. Seat of the primary process
  - Brain III: The NEO-cortex: cognition and memory

Benson's relaxation response

- Eyes closed, slow, gradual exhale, while relaxing hand
- Eyes closed, deep breath while pinching thumb and forefinger
- From conscious response to tension, to reflex

Ten principles of a responsive, interactive approach

1. Foster a secure, warm, positive attachment from the first phone call, by using **accurate empathy**; Speak to the normal person
2. Take a complete history, including childhood, ethnic, religious, and ancestral
3. Try the 3 phase treatment model; review and renew the contract with the patient, decide together when each phase is done

Ten principles of a responsive, interactive approach, p.2

4. Keep a constant feedback loop going, tying together new and old information: **Add psycho-education** to therapy
5. Use **motivational interviewing** techniques to encourage change; not only with the addictions
6. Align with the patient, and the patient will align with you

Ten principles of a responsive, interactive approach p.3

7. Be optimistic at the right time
8. Protect yourself; use your colleagues. Remember Michaelangelo at 87:
   - **"I am still learning"**
9. Do something proactive with the patient who makes you too unhappy, uncomfortable, or depressed. Get a consult.
10. When treatment gets stuck, share with the patient, and try another method

Conflicts between substance abuse and mental health treatment

1. Support and alignment v. confrontation
2. Therapist self–disclosure?
3. Non-directive v. directive
4. Building self-esteem v. shaming
5. Harm reduction v. abstinence
6. Agent of the patient v. agent of the program or of society
7. Trust the patient v. test the urine

Integrated treatments that work

- ACT
- PATHWAYS TO HOUSING
- PROTOTYPES
- Modified TC's
- Hall-Brooke+ Homestead
- TC's in prisons
- Community systems of care
- DBT for BPD

26+ therapeutic modalities

1. Psychoanalysis; various modifications
2. Psychodynamic psychotherapy
4. Medication as an adjunct, to make the profoundly depressed or psychotic patient available for therapy
5. Cognitive restructuring

Therapeutic modalities p.2

6. Psychodrama, role play
7. EMDR
8. Uncovering techniques: free associations, dream interpretation, etc.
9. Behavioral techniques
10. Motivational techniques, including **Motivational Interviewing**

Therapeutic modalities p.3

11. Dialectical Behavior Therapy (Linehan)
12. Psychoeducation: cognitive–emotional therapy Skills training
13. Supportive therapy
14. Family therapy, various schools: Ackerman, Minuchin, Bowen, ethnic focused
15. Conjoint couples therapy

Therapeutic modalities p.4

16. Paradoxical
17. Gender–focused therapy
18. Inclusion of significant others: spouse, partner, older children, for information gathering
19. Body work, acupuncture, Rolfing, Yoga, massage
20. Meditation, relaxation, hypnosis

Therapeutic modalities p.5

21. Unconventional means to change the transference: coffee shop, a hike in the woods
22. Religion-focused therapy
23. Bibliotherapy
24. Journaling, poetry
25. Adventure therapy

Therapeutic modalities p.6

26. For PTSD: immersion/ flooding/ exposure: Edna Foa

27. Group therapy-
a. Open or closed group
b. Time limited or not
c. Gender specific or co-ed
d. Homogeneous or heterogeneous
e. Psychoeducational or psychodynamic

Guidelines for psychoed class (Pepper)

1. Separate groups for pre-abstinent and abstinent
2. Co-leaders from MH & SA
   Alternate leading weekly
3. Contract for 8, 12, 16 weeks
4. One topic/week, on pad op
5. Newsprint pad on easel
6. Review last meeting at beginning of each week

Guidelines for psychoed class

7. No intoxication in meetings
8. No smoking or eating
9. Be punctual, don't leave
10. 45 minute group
11. Question, comment any time
12. No punishment for honesty

Guidelines for psychoed class

13. No long war stories; this is not therapy. Personal descriptions are to illustrate the educational topic.

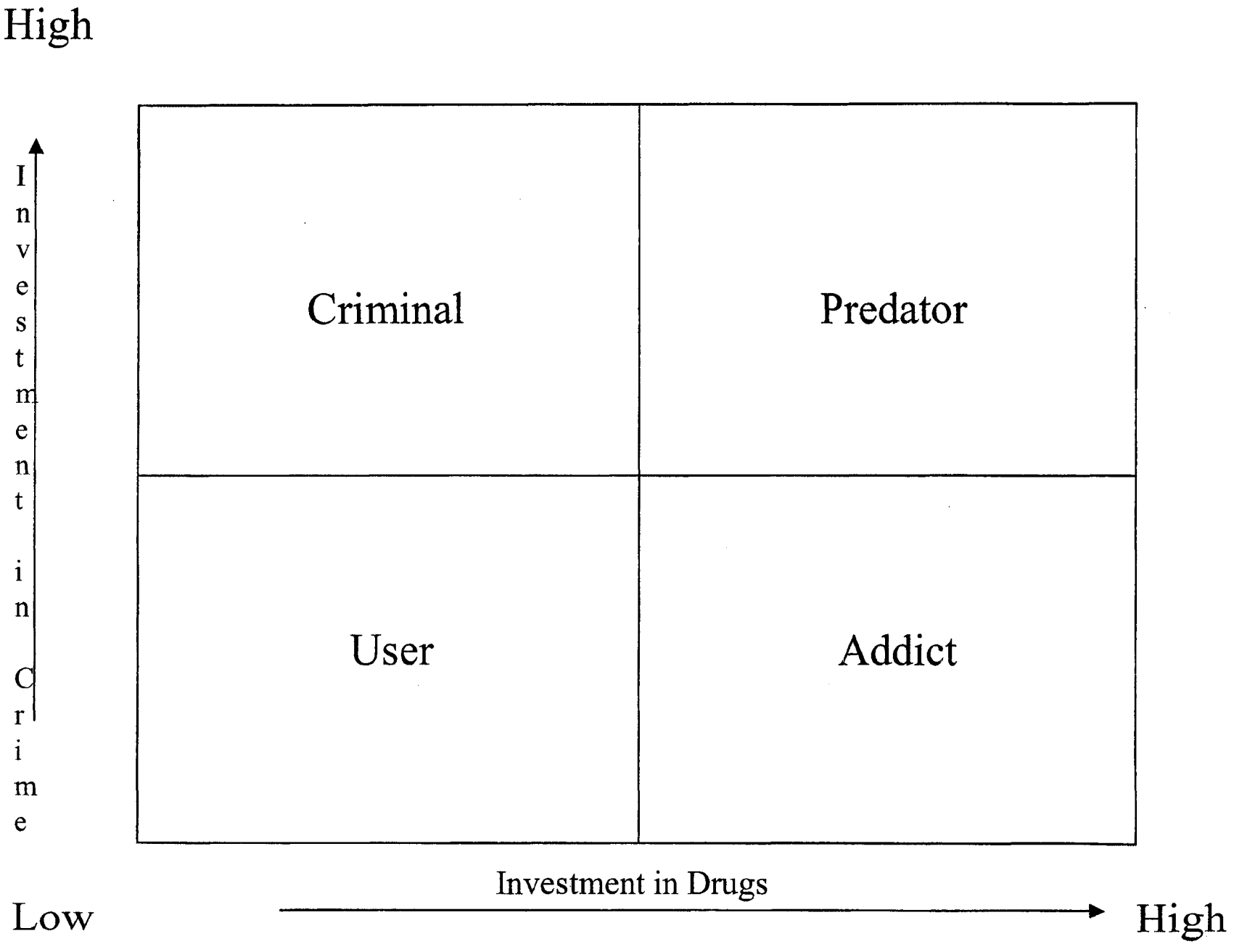
14. Anyone want to test abstinence in the group, and report any slip or relapse to the class?

Guidelines for psychoed class

1. Depression
2. Alcohol
3. Panic and anxiety
4. Marijuana
5. Extreme confusion (psychosis)
6. Cocaine
7. Three Kinds of medication (antidepressants, anti-psychotics, anti-anxiety
8. What drugs do to medication

County of Bucks
Department of Corrections

Harris Gubernick
Director of Corrections


High
Investment in Crime
Criminal
Predator
User
Addict
Investment in Drugs
Low
High

Responsivity

Professional Discretion

Predict Criminal Behavior

Match Treatment to Risk Level

Criminogenic

Noncriminogenic

Style and mode of offender

Style and mode of Provider

Professional Judgement

Big Four

- Criminal History
- Criminal Associations
- Anti-social attitudes
- Personality

Offender Attributes

- Impulsive
- Egocentric
- Habitual Anti-social Behavior
- Rigid / Narrow Thinking

Principles to Consider

- 1/3 – 1/3 – 1/3
- 80/20
- 20/60/20

Criminal Thinking Errors

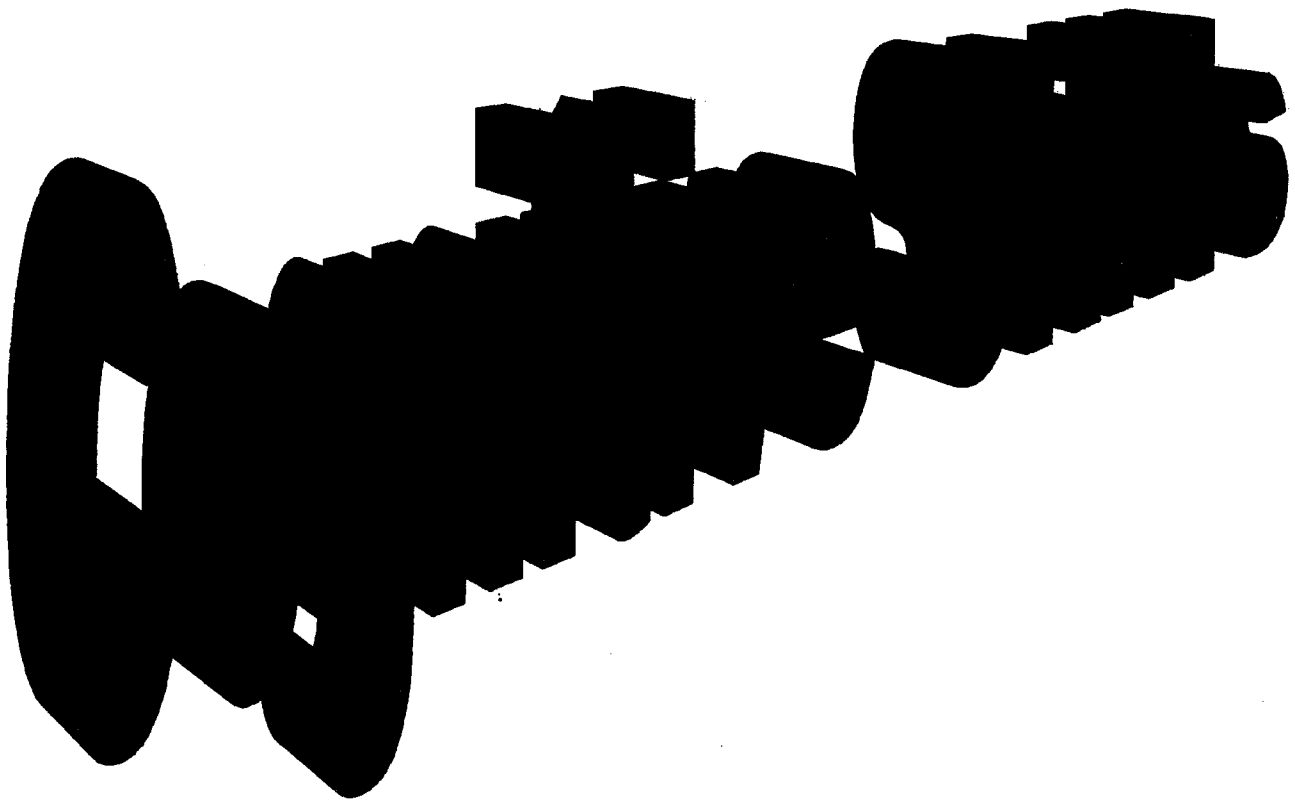
- Closed Thinking
- Victimstance
- Views Self as a Good Person
- Lack of Effort
- Lack of Interest in Responsible Behavior
- Lack of Time Perspective

Criminal Thinking Errors

- Fear of Fear
- Power Thrust
- Uniqueness
- Ownership Attitude

Patterns

- Victimstance
  - Look what you've done to me
- Dehumanization
  - They deserve what they get
- Entitlement
  - It's mine if I want it
- Righteous Anger
  - Victimstance with Emotion



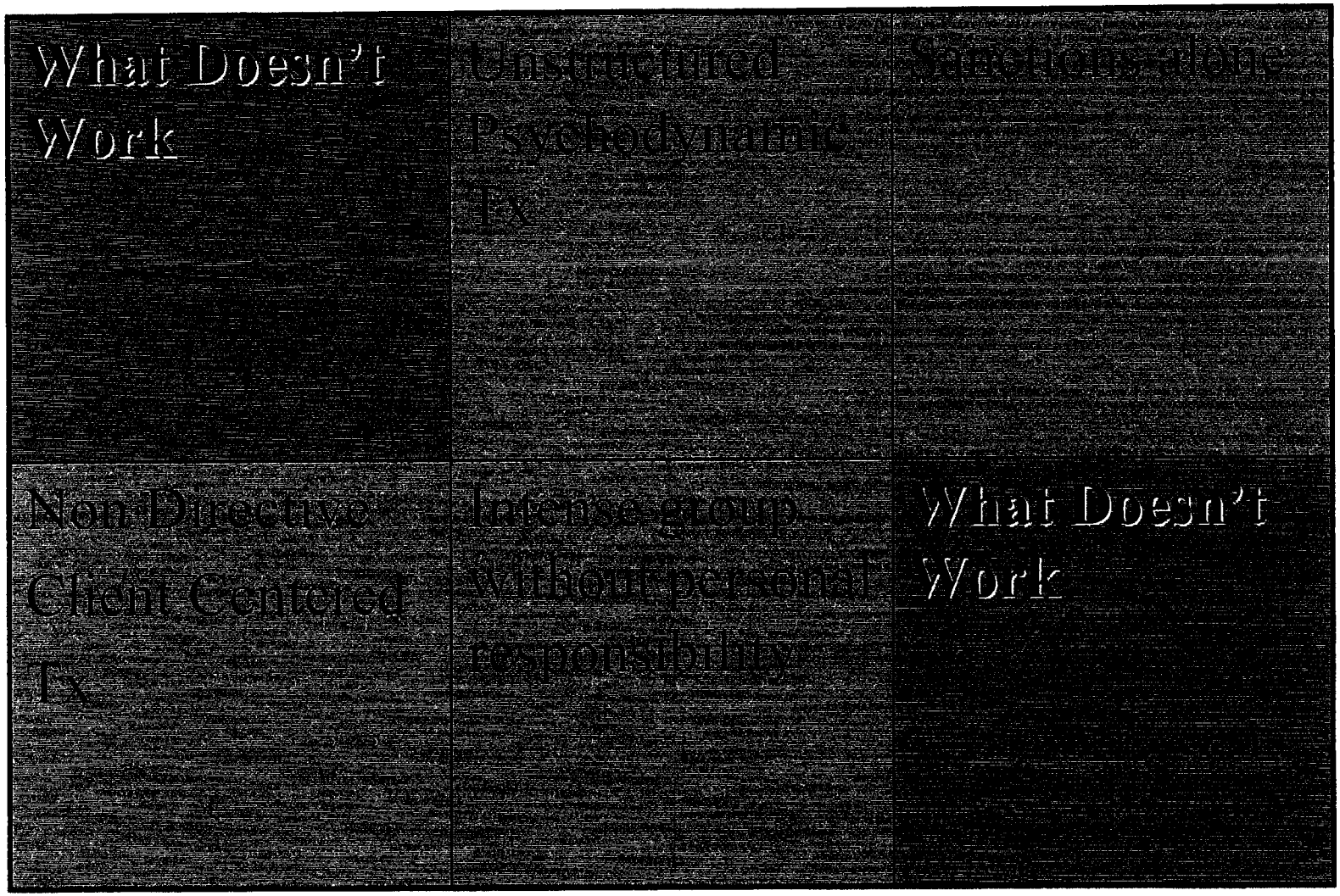
Never Learned


Learned but
Destructive

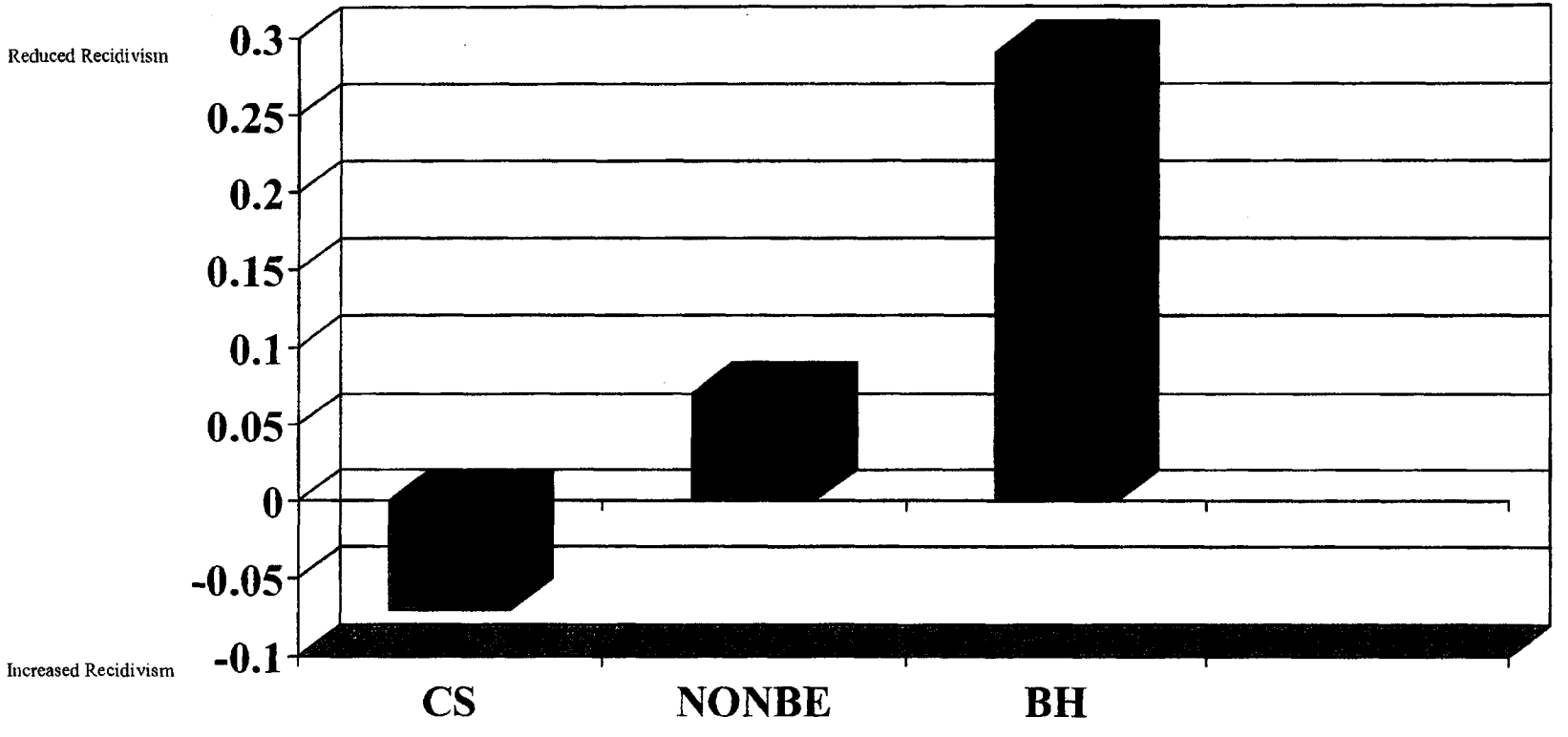
Cognitive Skill Areas

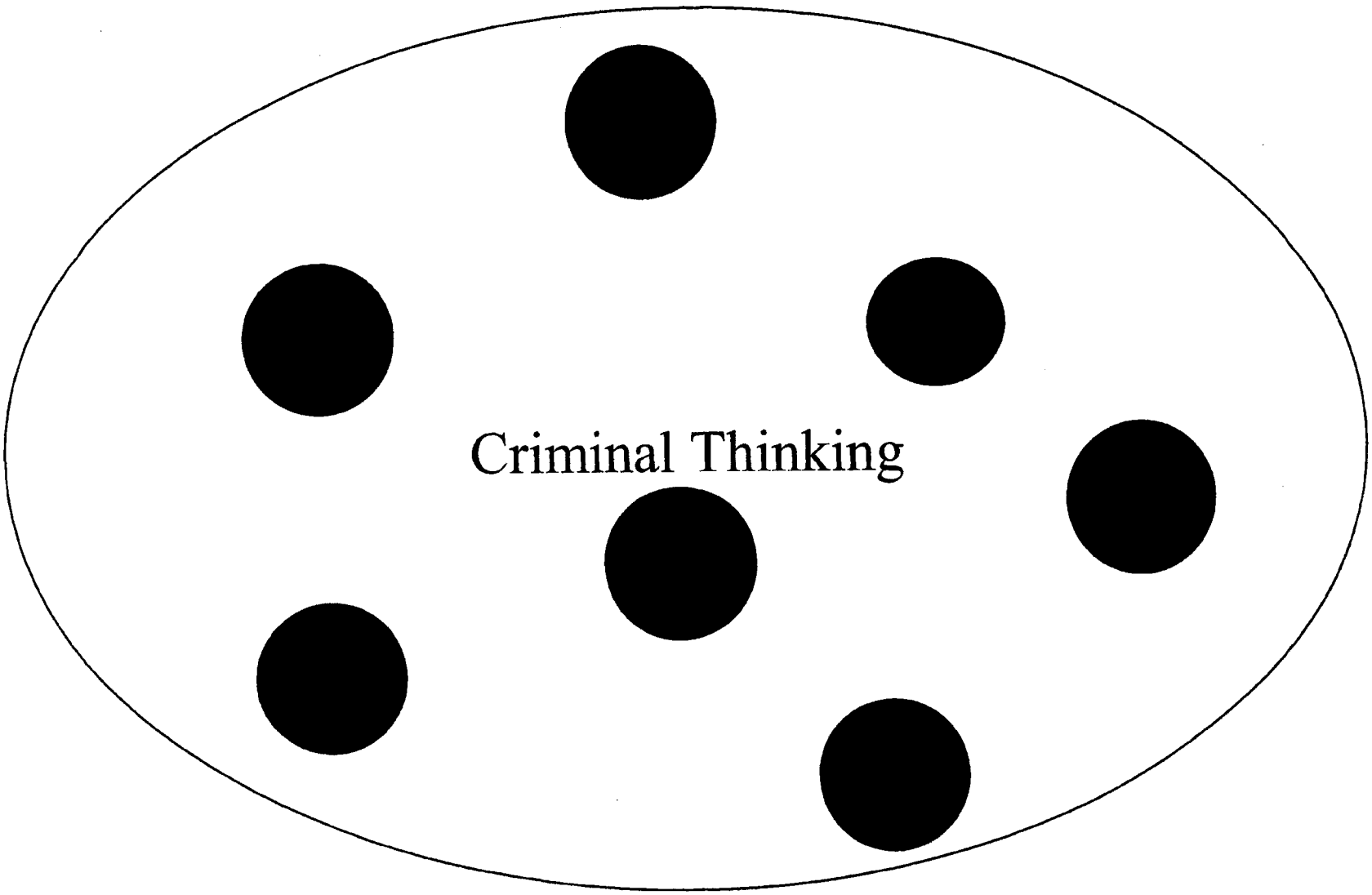
- Problem Solving
- Social Skills
- Creative Thinking
- Emotion Management

What Works


What Doesn't Work
Unstructured Psychodynamic Tx
Supportive alone
Non Directive Client Centered Tx
Intense group without personal responsibility
What Doesn't Work

Behavioral vs Non Behavioral Tx




Criminal Thinking

T TEACH SPECIFIC AND RELEVANT SKILLS

E EFFECTIVELY ROLE MODEL EACH SKILL

A ALLOW OPPORTUNITY TO PRACTICE EACH SKILL

C CLEAR AND CONSTRUCTIVE FEEDBACK

H HOMEWORK

LEARN

Law of listening skills

Expressing a complaint skill

Avoiding a fight skill

Responding with affection skill

Negotiating win-win outcome skills

Stop **Think**

STOP

Plan

Options

Access self/other/situation

Choose best option

VS

Tailor plans to success

R Responding

E Erratically

A And

C Causing

T Trouble

Treatment

System Integration

Supervision

Original: 2134

Council on Chemical Abuse

Concilio de Abuso de Sustancias Químicas

September 20, 2002

Mr. Robert Nyce, Executive Director
IRRC
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. Nyce:

This serves as a response to the proposed amendments to treatment standards for the approval of narcotic addiction treatment programs. While the majority of the new standards appear to be appropriate, there are three areas on which we would like to comment and make suggestions. These areas are specific to the psychotherapy services (section 715.19), the psychosocial staffing requirements (section 715.8) and urine testing (section 715.14).

Our comment to section 715.19 is not related to the amount of psychotherapy required for clients in treatment less than two years, but more so toward the requirements for clients in treatment beyond two years. It is not unusual for a client to be involved in Methadone maintenance for well beyond two years. In many of these instances the client is stable and uses Methadone as a maintenance medication (similar to a diabetic using insulin) and is not in need of psychotherapy services. To mandate such services could cause unnecessary hardship on the client, both in time and money, for services he/she does not need. Our suggestion would be to not require through regulation one hour of psychotherapy services for those in services beyond two years but, instead, leaving this clinical decision to the program's Medical Director. This would allow for a more clinically based offering of counseling services.

Additionally, the narcotics addictions treatment program standards would need to comply with section 704.12 regarding the full-time equivalent (FTE) maximum client/staff and client/counselor ratios. We believe that, while these ratios are appropriate for clients in a more acute treatment setting, these ratios are not necessary for maintenance-type programs. As noted above, there are typically many long-term clients (over two years) in a maintenance program who may no longer require regularly a scheduled counseling regimen. These clients are included in the client/counselor ratio even through they require very little monitoring by a

601 Penn Street • Suite 600 • Reading, PA 19601
Phone: 610-376-8669 • Fax: 610-376-8423 • Website: www.councilonchemicalabuse.org

counselor. While these long-term clients require monitoring, we believe they do not need the oversight of a qualified therapist. Therefore, we suggest that clients who, after a two-year period, no longer need regular counseling either not be counted towards the client/counselor ratio or be counted as some percentage of a client.

Finally, we believe that clients in the early stages of narcotic addiction treatment should be required to undergo more frequent urine drug testing than one per month. Our belief is that narcotic-dependent clients in the early stages of treatment need to be monitored closely for relapse into drug and alcohol use. Unchecked relapse will result in poor client treatment retentions and unsatisfactory long-term outcomes. We suggest that urine testing for the first two years of narcotic addiction treatment should be a minimum of once per week.

The opportunity to comment on the proposed changes in these treatment standards is appreciated. Please feel free to contact me for further clarification regarding any of the above comments.

Sincerely,

George J. Vogel, Jr.
Executive Director

cc: Representative Sheila Miller
Glenn Cooper, New Directions Treatment Program

Original: 2134

IRRC

From: Barlow, Todd [Barlow@pennfoundation.org]
Sent: Friday, September 20, 2002 8:46 AM
To: IRRC
Subject: Concerns over Chapter 715 Standards: Narcotic Treatment

Penn Foundation Recovery Center
807 Lawn Avenue
Sellersville, Pa. 18960

John R. McGinley, Jr., Esq., Chairman
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Chairman McGinley,

The purpose of this letter is to request on behalf of Penn Foundation Recovery Center that the Independent Regulatory Review Commission disapprove Chapter 715 Standards for Narcotic Treatment Program as submitted by the Department of Health.

Although we are not a methadone provider, heroin dependency is on the rise, even in our rural area. We need Methadone treatment as a part of our treatment continuum. It has been but a few years that such services have been available in our area. I am hearing, however, that the revised regulations a far different than regulations that would be considered best practice. This concerns me. I know what happens to over-regulated treatment services: they become marginalized and insufficient to meet client need. I hope that the State does not make that mistake.

We request that IRRC disapprove the regulations as submitted. We hope that the Department of Health be asked to revise several items after taking into account the concerns of those most knowledgeable in the field.

Sincerely,

Todd Barlow, MS
Director of Drug and Alcohol Services
Penn Foundation Recovery Center

Cc: PCPA

Original: 2134

BUCKS COUNTY DRUG & ALCOHOL COMMISSION, INC.
600 Louis Drive, Suite 102-A, Warminster, PA 18974
(215) 773-9313, Fax: (215) 956-9939
email: bcdac@co.bucks.pa.us

September 20, 2002

John R. McGinley, Jr., Esq., Chairman
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Chairman McGinley:

The purpose of this letter is to strongly recommend that the Independent Regulatory Review Commission disapprove *Chapter 715 Standards for Narcotic Treatment Programs*, as prepared and submitted by the Pennsylvania Department of Health.

The Bucks County Drug & Alcohol Commission, Inc. (BCDAC, Inc.) serves as the Single County Authority responsible for facilitating the provision of a comprehensive and balanced system of quality substance abuse prevention, intervention and treatment services for county residents. BCDAC, Inc. seeks to eliminate addiction, alleviate its effects and ultimately eliminate the abuse and misuse of alcohol, tobacco and other drugs in the county.

It is important to note that, while BCDAC, Inc. supports the need for revised methadone regulations to match the changes in federal regulations, we oppose the adoption of Chapter 715 as recently released on the basis that it is too restrictive. We in Bucks County have the unfortunate distinction of representing a region that is number one, nationally, in hospital emergency room visits due to opiate use. This region also has a high mortality rate related to narcotic abuse. Additionally, we have a great and growing gap of narcotic dependent individuals who cannot access treatment due to inadequate funding and inadequate treatment options. The problem of narcotic dependency is epidemic, as you no doubt know. Our efforts to educate our community at large, including consumers, providers and even state licensing bodies are numerous, but we need supportive laws and regulations to ensure that quality, cost effective and science based treatment options are available. Pharmacotherapy (including methadone) is an evidenced based treatment approach that we desperately need to expand in our region.

Most recently, our agency received a federal technical assistance grant from the Center for Substance Abuse Treatment, an arm of the Substance Abuse and Mental Health Services Agency (SAMHSA). We provided an intensive two-day conference entitled *Pharmacotherapy and Narcotic Dependency: Best and Promising Practices*, held September 9 and 10, 2002, in Langhorne, Bucks County. Nationally recognized experts in the field of narcotic dependency and pharmacotherapy, as well as consumer advocates, provided much-needed education regarding the best and promising practices. We will be continuing this technical assistance effort as we support programs to expand and provide more options for clients and families desperate for appropriate and effective treatment options. With all that science has to offer in our field and as acknowledged by the change at regulations at the federal level, we are deeply concerned that our own state Department of Health is proposing regulations that fly in the face of best practice standards and are not sensitive to the individual needs of clients.

We respectfully request that the proposed regulations be disapproved and revised by the Department of Health. The following is a listing of the some of the areas that we feel need to be re-written:

1. ***715.8 Psychosocial Staffing***

We feel that the proposed ratio of 35:1 is unreasonable for methadone programs. Although we do not believe that it is necessary to set a ratio and many states do not. A 50:1 would be more reasonable, if we must go with one. A larger ratio has been recognized as a best practice standard because all programs have a balance of individuals who need intensive treatment focus, as well as clients with many months and years of sobriety who no longer need intensive treatment but are self-sufficient, tax paying and law abiding community members. The PA Department of health's proposed regulation is unnecessarily restrictive and a cost driver for our treatment system.

2. ***715.19 Psychotherapy Services***

Pharmacotherapy is a highly individualized treatment regiment. Clients, who have demonstrated their sobriety through life changes, and a variety of other commitments, should not be held to the same standard as a client just entering this treatment regimen. They need fewer treatment episodes on average and certainly do not need the level as proposed in these regulations. The federal government has acknowledged this in their regulations, as do pharmacotherapy best practice standards. One way to approach this would be to exclude individuals with an agreed upon level of seniority in the program from this ratio requirement.

On another level, nowhere else in laws or regulations is there a requirement that a client receive a certain level or amount of treatment, whether they need it or not. Best practice standards indicate that the qualified professionals who are working with clients should individualize treatment to patient need. Sometimes this means placing the client in a higher level of care, including residential, partial hospitalization and intensive outpatient services. On the back end, however, most clients need very little formal therapy after they have been maintained on medication for a number of months. Certainly this would also be true for clients on medication for two or three years and more.

As a payer for services, we are also seriously concerned as to the financial impact of this therapeutic requirement. We are unable now to pay for all of the services provided within treatment programs for clients eligible for Medicaid funding or for other state and federal public dollars. Thus clients would most likely end up paying for a service that is not only unnecessary, but also intrusive and counter to our goal of self-sufficiency within the community. Does it make practical or clinical sense to require the same level of therapy for a new client as for someone who has been in the program for two years? We think not.

3. ***715.25 Prohibition of Medication Units***

Medication units are essential to pharmacotherapy treatment. The federal definition of this level of care states that the medication units are part of a comprehensive narcotic treatment program. Thus any medication unit operating within this definition and federal regulation would be part of a larger agency that would provide a full range of clinical services at its main site. With few pharmacotherapy clinics available to those who need them now, medication units operating within the new federal guidelines presents a very important option to us. One such unit is now being proposed in Lancaster and we are hoping to start one in our county later this year.

Clients in methadone treatment usually have to pick up their medication six days of the Week. Even in a suburban area such as ours, this can mean a 45-minute drive to a clinic, before driving on to work. This is day in and day out, 52 weeks a year. We know that requiring them to come back additional times for therapy and other support services is extremely difficult, particularly if the client does not have private transportation. One sensible option is to allow clients to pick up their medication at a local pharmacy or other appropriately licensed entity as defined under the federal regulations as a medication unit. Then they would only need to come to the clinic for their therapy.

We should note that transportation costs are a major cost driver for public funded treatment. We are already now paying tens of thousands of dollars to transport clients on a daily basis to and from a centrally located methadone clinic due to lack of adequate public transportation. Transportation is a real barrier to treatment for many folks here and I imagine that it is much more so in rural parts of this state.

We strongly object to the Pa Department of Health's current effort to prohibit our local and best practice efforts to expand availability of an important treatment alternative and to make treatment more accessible to clients.

4. ***715.7 Dispensing or Administering Staffing***

The proposed 200 patient limit is unreasonable. We have not located any research-based evidence, which stipulates that any limit must be imposed, nor do the federal regulations acknowledge this need. In addition, we disagree with the proposed 15-minute time period for dosing.

Last, but certainly not least, we feel it is imperative that the field be involved throughout the process of development and adoption of new regulations. We do not feel that consumers have sufficiently and in good faith been involved in the consideration of these proposed regulations. Nor do we feel that the thoughts and concerns of those professionally involved in the treatment of clients with a narcotic dependency have been carefully considered.

We deeply respect your Independent Regulatory Review Commission's task of addressing narcotic treatment. We ask that you carefully consider our remarks and those of other advocacy organizations. The proposed regulations are not in the best interest of our clients, nor do they match the intention of our lead agencies responsible for financing of treatment for narcotic dependency.

I am sending via a separate mailing a packet of information from our recent conference for your review. I am available to further illustrate our concerns with the Pennsylvania Department of Health's proposed regulations, and appreciate, in advance, your consideration of the concerns we raise on behalf of the consumers of Bucks County.

Sincerely,

Margaret E. Hanna
Executive Director

Enclosure

cc: Jim Connolly, Eastern Regional States Representative, National Association for Methadone Advocates
Peter Pennington, Executive Director, Pennsylvania Association of Methadone Providers
Gene Boyle, Director, PA Department of Health, Bureau of Drug and Alcohol Programs
Gerald Radke, Director, PA Department of Welfare, Office of Mental Health and Substance abuse Services
Kathy Hubert, Executive Director, PA Association of County Drug and Alcohol Administrators
Lynn Cooper, Senior Policy Specialist, PA Community Providers Association
Bob Waters, Executive Director, Magellan Behavioral Health of Pennsylvania
Michael Ratajczak, Executive Director, Aldie Foundation, Inc.
Mark Besden, Executive Director, Discovery House
Glen J. Cooper, Executive Director, New Directions Treatment Center, Inc.

BUCKS COUNTY DRUG & ALCOHOL COMMISSION, INC.
600 Louis Drive, Suite 102-A, Warminster, PA 18974
(215) 773-9313, Fax (215) 956-9939

FAX COVER SHEET

DATE: 9/23/02

TO: JOHN R. McGINLEY, JR., ESQ.
INDEPENDENT REGULATORY REVIEW COMM

FAX # 1-717-783-2664

FROM: MARGE HANNA

TOTAL NUMBER OF PAGES INCLUDING COVER SHEET: 5

[X] Original Will Follow
[ ] Original Will Not Follow

IF YOU HAVE ANY PROBLEMS RECEIVING THIS TRANSMITTAL, PLEASE CALL THE PERSON ABOVE AT 215-773-9313.

COMMENTS:

inal: 2134

Alliance Medical Services, Inc

September 18, 2002

Robert Nyce, Executive Director
IRRC
14th Floor
333 Market St.
Harrisburg, PA 17101

Re: Proposed Methadone Regulations (§715.1 - 715.30)

Dear Mr. Nyce:

We are taking this opportunity to provide our comment on the proposed methadone regulations currently under consideration by IRRC. Alliance Medical Services is a methadone maintenance provider operating in the Pittsburgh area.

To begin, we would like to thank the representatives from the Department of Health for their sincere interest in the methadone field. With over 800 facilities state-wide to license and monitor, the Department continuously demonstrates their support for the value of maintenance services by remaining accessible to the field and by continually working to increase their own knowledge of methadone services. The regulations before you are the result of an ongoing give-and-take process that involved several years of effort and the collaborative involvement of both government and service providers.

You will hear comments from others in the field opposing much of what Pennsylvania and the Department of Health are suggesting as regulatory requirements. You will hear that in other states counselor/patient ratios are not mandated, counseling time is not mandated, physician and nursing hours requirements are not set and so forth. *Please remember that in viewing comparisons to other states, Pennsylvania is leading the way by demanding quality services.* The Department is not micro-managing and placing unreasonable requirements on the field. While we may not agree in total with the regulations, the intent and the vast majority of the content strives to guarantee patients a quality, life-saving service. Some specific comments regarding various parts of the regulations follow:

- *35/1 Patient/Counselor Ratios:* There has been discussion among providers regarding the 35/1 staff/patient ratios, but we do not feel that increasing that ratio would be clinically advisable. *The success of a methadone program depends upon the strength of its clinical services, not on the simple provision of a medication.* Methadone does a wonderful job of eliminating the craving for opiates, but long-

term patient success is only achieved by coming to understand the root causes of addiction, and developing well-internalized strategies to deal with it on a life-long basis. The patient population we see at Alliance both needs and benefits from the level of treatment they currently receive, and reducing the available staff hours for treatment would certainly have a negative impact on treatment outcomes.

- *The 2.5 hour counseling requirement:* Since opening, Alliance has recognized that there is a high – likely over 50% – coincidence of mental illness among our patient with the concomitant necessity of providing increased services here as well as coordinating with community based mental health providers. It's my personal experience, over the past twenty years, that the patient population is becoming more infirm, both physically and behaviorally, and more therapeutic intervention is required both for the good of the patient and the community. The 2.5 hour requirement is actually much lower than what is most often clinically advisable, and in the best of all worlds, with adequate financial support, it would be higher.

- *Physician / Nursing time requirements:* We do feel that the requirements for physician/CRNP/PA time as drafted are unnecessarily high and will result in programs having more of a medical presence than is predicated by need. It is logical to have one third of the time commitment derive from physician time, but unless clinics are to move into the business of providing primary healthcare, the 1 hour /10 patients per week will place a financial burden on programs while not providing a qualitative return on investment.

  The change in the requirements for dispensing staff as proposed are realistic, and should not be lessened.

- *Maximum dosing time*: The requirement to move patients through the dosing process in 15 minutes or less should be maintained. To increase this level, or to eliminate it, results in patients being treated in a less than humane fashion and increases the potential for loitering on the clinic grounds.

- *Take-Home Medication:* Recently federal requirements have been changed to permit some patients the ability to have a month's supply of medication in their possession at any time. We are adamantly opposed to this lessened requirement, and caution reviewers to understand that methadone is a Schedule II narcotic. As proposed by Pennsylvania, requiring patients to come to a clinic once a week is not burdensome to the patient and is responsible.

We thank you for the chance to provide our input. We could comment further, but the points above should make our position clear: with the possible exception of physician/patient ratios, Alliance Medical gladly supports the proposed 715 regulations.

Sincerely,

Stephen Shaner, Director

ATS
Advanced Treatment Systems

Original: 2134

September 20, 2002

Chairman John R. McGinley, Jr.
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. Chairman;

I am submitting formal comment regarding regulations proposed by the Department of Health, Standards for Approval of Narcotic Treatment Programs (IRRC Number 2134) representing Advanced Treatment Systems, Inc., Coatesville, PA. ATS has been a licensed narcotics treatment program since May 1998.

By way of introduction, I am a Pennsylvania Licensed Social Worker, have been in the addictions treatment field since 1969, and currently serve as an Opioid Treatment Program surveyor for CARF, one of the federally approved accrediting bodies for such programs across the country.

The Department's proposed regulation has developed at a pace behind national progress in the field. We believe the Department should review these developments and update proposed regulations.

These changes in the field of narcotics addiction treatment are due to both increases in *science* and in *demand* for services directly related to greater numbers of opioid addicted individuals across the country, including Pennsylvania. The greatest change in the field relates to how the Federal Government regulates such programs. Formerly supervised by the Food and Drug Administration, such programs are now under supervision of SAMHSA's Center for Substance Abuse Treatment (CSAT), Office of Pharmacologic Therapies.

After lengthy review of the old regulations and rules for federal oversight, CSAT determined that methadone treatment facilities should begin to be considered as part of mainstream healthcare. To this end, CSAT implemented rules requiring independent accreditation (JCAHO, CARF, etc.) for all such providers across the country. They simultaneously developed treatment standards in accordance with *best practice guidelines*. While we support the Department's efforts to update these regulations, our hope to see more of these guidelines reflected in the final product.

The following comments reference specific proposed regulations:

701.1 Definitions; Narcotic treatment physician.

This level of training requirements is excessive and will serve to discourage physicians from working in clinics. Note that Buprenorphine rules require only 8 hours of training before being approved to treat heroin addicts in a primary care practice.

715.5 Patient Capacity

Most states do not regulate patient census; the Department's current regulation of census results in waiting lists at most clinics. The Department should either develop standards permitting interim maintenance or develop strategies to assure the elimination of waiting lists due imposed limits on capacity.

715.6 Physician staffing

Physicians, Nurse Practitioners and Physician's Assistants are already regulated by the Department of State. It is unnecessary for the Department of Health to impose additional rules for the treatment of opioid addiction. By doing so, the field of narcotics addiction treatment is further stigmatized among such licensed practitioners.

715.7 Dispensing or administering staffing

Increasing nursing FTE's does nothing to improve quality or efficiency of operations in a clinic. However, the number of dispensing stations does both. This regulation will allow providers with only one dispensing station to continue experiencing long waiting lines while having more nursing FTE's than available nursing duties.

715.8 Psychosocial Staffing

The Department is correct in its desire to assure psychosocial services to patients. However, this standard is excessive. This proposed standard fails to take into consideration the longevity of patients in treatment. Currently, patients who have completed their psychosocial treatment are thought to have the same therapy needs as a newly admitted patient. In reality, such patients continue participation in the clinic only because the clinic is the only place they can receive their medication. Adhering to a ratio of 1 to 35 destroys productivity standards for counselors, is wasteful of limited resources, and forces patients without the need for counseling to endure sessions they consider ridiculous.

715.16 Take Home privileges

It is clear that the stigma associated with heroin addiction influenced development of this regulation. There is no evidence that such patients divert medication to the illicit market. Patients with long-term demonstrated success in treatment should be permitted "take home" medication according to the schedule proposed by CSAT. This regulation in particular will result in patients crossing state lines to obtain take home privileges.

For those patients who have proved that "treatment works" and have "recovered" from the addicted lifestyle they had at the time of admission, the clinic environment itself is the most deviant they visit. A comparable example would be for recovering alcoholics being required to visit a Detox center daily.

715.21 Patient Termination

Healthcare providers should not be prohibited from discharging persons who no longer pay for their services.

In summary, we are requesting that final approval of this proposed regulation be delayed and that Department seek input from a "blue ribbon panel" of current providers, CSAT officials, and national experts to reframe designated standards. We are aware that IIRC procedures allow a 45-day period to accomplish this.

I expect to attend the hearing on September 26, 2002.

Sincerely,

Jeffrey J. Kegley
Executive Vice President

PCPA
Pennsylvania Community Providers Association

Original: 2134

PCPA promotes a community-based, responsive and viable system of agencies providing quality services for individuals receiving mental health, mental retardation, addictive disease and other related human services.

2400 Park Drive • Harrisburg, PA 17110-9303 • Tel: 717-657-7078 • Fax: 717-657-3552 • mail@paproviders.org • www.paproviders.org

John R. McGinley, Jr., Esq., Chairman
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Chairman McGinley,

The purpose of this letter is to request on behalf of the members of the Pennsylvania Community Providers Association that the Independent Regulatory Review Commission disapprove Chapter 715 Standards for Narcotic Treatment Program as submitted by the Department of Health.

The Pennsylvania Community Providers Association (PCPA) is a private non-profit association representing nearly 200 community-based agencies that provide mental health, mental retardation, substance abuse, children's, and other human services. Nearly half of PCPA's 200 members provide drug and alcohol services. Our members cover all 67 counties in the Commonwealth, and it is estimated that they serve almost 1 million Pennsylvanians each year.

PCPA was founded in 1972, and since that time has represented providers on legislative and regulatory matters. The association works closely with the various departments within the administration and with members of the legislature.

First and foremost we want to acknowledge that we understand that this is an extremely difficult and controversial subject. We do not believe that it should be but we realize that it is indeed. Drug and alcohol treatment is not fully understood by many. Methadone treatment is even more misunderstood. PCPA represents five methadone treatment agencies directly. However, as stated above, we represent almost 100 drug and alcohol treatment facilities, all of which are effected indirectly by these regulations. Methadone is a crucial modality of service that must be available in the commonwealth. Many PCPA members refer to the methadone providers for these needed and already scarce services.

The American Society of Addiction Medicine has stated, "Methadone maintenance is effective and safe and is an integral part of addiction medicine." Also, Richard M. Glass, M.D., Deputy Editor of the Journal of American Medical Association has stated " the available evidence indicates its effectiveness in reducing intravenous drug use and crime and in enhancing social productivity, with methadone maintenance showing a clear advantage over the other treatment modalities available for opioid addiction." In addition, an expert panel at a National Institutes of Health Consensus Development Conference on Effective Medical Treatment of Heroine Addiction concluded that heroine addiction could be effectively treated in methadone programs. The consensus panel strongly recommended expanding access to methadone treatment by eliminating excessive federal and state regulations and increasing funding for methadone treatment.

It is important to note that PCPA strongly supports the need for new methadone regulations; however, we oppose the adoption of Chapter 715 as recently published. We believe that the regulations as submitted are unreasonable, costly to the commonwealth and are not in the best interest of public health, safety, and welfare of Pennsylvania citizens.

We request that IRRC disapprove the regulations as submitted and that the Department of Health be asked to revise several items after taking into account the concerns of those most knowledgeable in the field as well as that which is consistent with most other states, with accreditation agencies, and with the recommendation of national experts

PCPA has been working with the Pennsylvania Association of Methadone Providers for over two years on the new Methadone Regulations. Letters were submitted to the Department of Health in July of 1999 and August of 2000 expressing concern about the proposed regulations. In an effort to support the new regulations our Association has narrowed our request for changes dramatically.

The following is a summary of the four areas we recommend the Department change:

715.8 Psychosocial Staffing

The counselor to patient ratio of 35- 1 is inappropriate for Methadone Programs. We understand that this is the ratio in

Chapter 704 of the staffing regulations for outpatient clinics but we believe strongly that this is inappropriate for methadone services. Many programs have long-term stabilized patients on reduced counseling schedules. The 35-1 requirement is beyond what are in "best practices" accreditation standards and what most other states with a substantial methadone patient population require. Likewise, FDA/NIDA federal guidance has been a 50:1 ratio. Chapter 704 regulations on this subject are not appropriate for methadone treatment where fully rehabilitated patients remain in treatment often for years at a time. We advocate that the ratio be changed to 50:1 if a ratio must be employed. Most states have no ratio. We strongly believe that the Department has failed to provide any data to support how the ratios were developed and/or that they are reasonable or appropriate to protect public health, safety and welfare.

715.19 Psychotherapy services

This section specifies that all patients in treatment for a particular length of time receive what are quantitatively the same counseling services. This requirement is inappropriate and wasteful. There is an acute lack of resources in regard to methadone treatment generally. Every dollar must be spent with utmost care and no resources can be wasted. The language should exempt from any counseling requirement for those patients who have shown evidence of being rehabilitated and free of illicit drugs for an extended period of time as certified by the medical director. It is a common scenario where a patient left treatment voluntarily and later returned because of a recent or impending relapse. Such patients often have an ongoing need for medication but have already had years of counseling and should not have to pay for or receive counseling services which they don't need and can't afford. Services provided must be services that are clinically driven and medically necessary. Again, we maintain that the Department has failed to provide any justification for this regulation.

715.25 Prohibition of medication units

The department, in its comments response, misstates the nature of medication units. It is untrue that persons medicated at medication units do not receive counseling or other comprehensive services. In fact they do receive comprehensive services. The federal definition states that the medication units are part of a narcotic treatment program and the federal definition of narcotic program requires

comprehensive services. The department simply objects to physically separating the medication function from the other functions. In a large, mostly rural state with few methadone programs, medication units are essential. Many persons cannot drive 100 or 150 miles round trip daily and doing so prevents employment and other patient advancements. Coming to the clinic site once per week for counseling and other services while getting daily medication closer to home is much more feasible and cost effective. The current prohibition also is costing the Commonwealth hundreds of thousands of dollars per year in mileage payments to Medical Assistance patients. If the department is concerned about such units being "hundreds of miles" distant, we do not object to reasonable restrictions rather than outright prohibition. The Department has failed to provide any justification for the prohibition of medication units. We maintain that the limited accessibility that these regulations impose cause increased costs, and jeopardizes public health, safety and welfare.

715.7 Dispensing or administering staffing

(a)(1) - The language specifying one full-time equivalent dispensing staff for 200 patients is excessively restrictive, and should instead reference 300 patients. Neither accreditation standards (e.g., JACHO, CARF) nor most other states specify any maximum number (see enclosed). Again, we strongly believe that the Department has failed to provide any data to support how these ratios were developed and/or that they are reasonable or appropriate in any way to protect public health, safety and welfare.

(b) - We object to new language specifying a 15-minute time period for dosing. This requirement is excessively restrictive and has not been subject to normal rule-making comment procedures. We are unaware of any other state that has any similar time restriction. We believe a time limit of this type is inappropriate for state regulation and respectfully ask when private doctor's offices and dentist's offices might have to comply.

On a separate but related note PCPA would like to take this opportunity to state our objections to the process that the Department has used to advance these regulations.

1. The stakeholder meeting was flawed and needs to be improved. Even participants of the group felt their concerns fell on deft ears.

2. The Department has disregarded Federal Regulations, regulations in most states in this country, and the major accrediting bodies, JACHO and CARF, referring to them as "lap dogs of the industry".
3. The providers that must implement these regulations were refused numerous times over the last two years to be a part of the revision of the regulations. No opportunity has been given for discussion of the changes since the first comment period two years ago. Numerous requests were made to the Department to learn what revised regulations would be proposed and all requests were refused. In fact, on several occasions, department officials went so far as to tell providers that they would like the changes that had been made. That of course is not the case.
4. The Department submitted the regulations to IRRC late in the process, close to a holiday weekend, and while the legislature was not in session. This has made it all but impossible to use remedies that would have otherwise been available to those most effected by the regulations.

We respectfully request that IRRC disapprove the regulations as submitted and that the Department of Health be asked to revise the items listed above after taking into account the concerns of those most knowledgeable in the field as well as that which is consistent with most other states, with accreditation agencies, and with the recommendation of national experts.

Sincerely,

Lynn Cooper
Senior Policy Specialist

PCPA
Pennsylvania Community Providers Association

Pennsylvania Community Providers Association
2400 Park Drive
Harrisburg, PA 17110
717-657-7078
717-657-3552 FAX

To: Jim Smith
Fax Number: 783-2664
From: Lynn Cooper / PCPA
Date: 9/18/02
Re:

Just in case —

See you at 8:30.

Lynn Cooper

Original: 2134

Alliance Medical Services, Inc

729 Ensign Avenue
Pittsburgh, PA 15226

September 18, 2002

Robert Nyce, Executive Director
IRRC
14th Floor
333 Market St.
Harrisburg, PA 17101

Re: Proposed Methadone Regulations (§715.1 - 715.30)

Dear Mr. Nyce:

We are taking this opportunity to provide our comment on the proposed methadone regulations currently under consideration by IRRC. Alliance Medical Services is a methadone maintenance provider operating in the Pittsburgh area.

To begin, we would like to thank the representatives from the Department of Health for their sincere interest in the methadone field. With over 800 facilities state-wide to license and monitor, the Department continuously demonstrates their support for the value of maintenance services by remaining accessible to the field and by continually working to increase their own knowledge of methadone services. The regulations before you are the result of an ongoing give-and-take process that involved several years of effort and the collaborative involvement of both government and service providers.

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term patient success is only achieved by coming to understand the root causes of addiction, and developing well-internalized strategies to deal with it on a life-long basis. The patient population we see at Alliance both needs and benefits from the level of treatment they currently receive, and reducing the available staff hours for treatment would certainly have a negative impact on treatment outcomes.

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- *Take-Home Medication:* Recently federal requirements have been changed to permit some patients the ability to have a month's supply of medication in their possession at any time. We are adamantly opposed to this lessened requirement, and caution reviewers to understand that methadone is a Schedule II narcotic. As proposed by Pennsylvania, requiring patients to come to a clinic once a week is not burdensome to the patient and is responsible.

We thank you for the chance to provide our input. We could comment further, but the points above should make our position clear: with the possible exception of physician/patient ratios, Alliance Medical gladly supports the proposed 715 regulations.

Sincerely,

Stephen Shamer, Director

Original; 2134

CITY OF PHILADELPHIA

THE OFFICE OF BEHAVIORAL HEALTH/
MENTAL RETARDATION SERVICES

COORDINATING OFFICE FOR
DRUG AND ALCOHOL ABUSE PROGRAMS
1101 Market Street, Suite 800
Philadelphia, PA 19107-2908

MARK R. BENCIVENGO
Executive Director

September 13, 2002

Robert Nyce, Executive Director
Interagency Regulatory Review Commission (IRRC)
333 Market St. 13th Fl
Harrisburg Pa. 19101

Dear Sir :

With the release of the final-form regulations (Department of Health Regulations No. 10-159), Standards for Approval of Narcotic Treatment Programs, it is our understanding there are now efforts to have some of these regulations altered. Ideally, the treatment of patients in need of medical/behavioral healthcare should be governed by professionally directed providers following best practice standards (i.e.,SAMSHA/CSAT regulations). In this letter, we have identified a number of sections of the regulations where we feel strongly that change would be inopportune while in others where what is proposed should most certainly be supported.

1. Section 715.6. Physician Staffing; subsections (d) and (e), i.e., staffing ratios for physicians and certified health care professionals providing treatment to patients in narcotic treatment programs. The regulation ratio is one (1) physician hour to every 10 patients per week.
   There are requests, for economic reasons that the ratio be increased adding several more clients to one (1) physician hour

   Comment:: This recommendation is not consistent with the needs of a highly diverse patient population , many of whom are growing old and have many different medical conditions and/or complications which must be addressed in their treatment. Also the amount of time needed to properly initiate, orient, and stabilize medication regimens suggests that the present physician to client ratio should in no way be increased.

2. Section 715.8 Psychosocial Staffing; subsection (6), Outpatient Counseling Caseload.
   The regulation establishes a ratio that may not exceed one (1) FTE counselor in an outpatient narcotic treatment program to thirty-five (35) active patients. There are requests to increase the counselor to patient ratio by several clients. The reasons proposed are that there are a number of patients in programs who do not need as much time and attention.

   Comment:: The one counselor to thirty-five patients should not be increased. It is true that components of the treatment populations in narcotic treatment programs have been in treatment for some time, are stable and need less intense interventions. It is also true that there have been significant increases in newer, sicker patients who are more challenging to a newer more inexperienced though educationally improved staffs. Additionally with the inclusion of counselor assistants to the staffing ratio, the increasing of the counselor to client ratio may not allow for consistent professional growth and lead to burnout.

3. Section.16. Take-Home Privileges; subsection (e)
The regulation requires (with an exception) a patient in a Narcotic Treatment Program receive no more than a two (2) week take home supply of medication.
There are requests to allow more senior patients, with substantial "clean time" and 5+ years in treatment consideration for more take homes than what is allowed.

   Comment:: This request is consistent with best practice and the current time frame could be changed to allow more flexibility for patients with documented long term stability, established clean time, consistency of appropriate behaviors, and adequate means to secure the medication.

4. Section 715.21. Patient Termination; subsection (1) Involuntary Termination. The regulation does not allow for a provider to involuntarily terminate a patient for non-payment of fees.
There are requests to allow providers to allow for non-payment of fees to be specifically included as a justification for termination.

   Private pay patients do not represent the majority of clients in the MMT population. A blanket allowance to discharge a patient involuntarily for non-payment of fees does not account for those clients who are Medicaid dependent, loose their coverage, are put on a fee paying agenda, become delinquent, get reinstated on Medicaid and have a bill. It also does not allow for clients who were once paying out-of-pocket and become delinquent while transitioning to Medicaid coverage. We must remember that patients who are involuntarily discharged not only are a threat to themselves but to the public safety. Because of the nature of Opiate Addiction Pharmacotherapy and the lack of access on demand, we cannot count on someone who is involuntarily discharged being able to find treatment elsewhere. It is true that programs need to be fiscally efficient and able to collect fees from their fee paying clients, but it is the contention of this SCA that a client's inability to pay should never be used as a reason to stop or to prevent someone from initiating treatment.

   We greatly appreciate the opportunity to present this information to the Commission. We feel strongly that our positions will be most beneficial to the continuing care of opiate addicted clients throughout the state.

Sincerely,

Mark R. Bencivengo
Executive Director

Cc: William Thompson

Sean Gallagher

Roland Lamb

Original:2134

Capital Region Health System

@ Hamilton Health Center, Inc

September 12, 2002

Robert Nyce
Executive Director
IRRC
14th Floor
333 Market Street
Harrisburg, PA 17101

Dear Mr. Nyce:

This letter is in response to the comments related to the PA Department of Health's proposed regulations for narcotic addiction treatment programs.

Hamilton Health Center is a community based health center that provides physical and behavioral health care to insured, underinsured and uninsured persons. Hamilton Health Center's senior management staff includes several persons with an extensive history of substance abuse experience at both the state and provider level. Hamilton Health Center has partnered with Dauphin County Department of Drug and Alcohol Services to coordinate behavioral and physical health care to individuals with substance abuse disorders. These programs include substance abuse assessment, maternal addiction and HIV/STD prevention education. Hamilton Health Center also partners with several substance abuse facilities to provide health care services, including HIV/AIDS to patients in drug and alcohol programs. Hamilton Health Center is very interested and concerned with the services provided by the narcotic addiction treatment programs and the proposed DOH regulations

I have been the director of a narcotic addiction treatment program in Harrisburg and am familiar with the treatment practices and problems of a methadone facility. I have reviewed the comments on 28 Pa. Code Chapter 715 relating to the standards for approval of narcotic treatment programs. The Department of Health has reconsidered and amended their position on many of the standards the narcotic addiction treatment programs took issue with, however several standards the Department of Health upheld. Based on my experience, I would like to address those standards that are significant to an effective recovery process

- **Section 715.3 Approval of narcotic treatment programs. Standards and guidelines maintain quality and performance within a facility and ultimately improve patient care. Every facility should be operating according to Federal and State regulations and be prepared for inspection at any time.**

- **Section 715.6 Physician staffing. Generally physicians are not required to take courses related to addiction medicine. While a physician may provide exemplary health care they do not have the skills to provide appropriate care and treatment for individuals with substance abuse disorders. Credentialing is a mark of professional accomplishment that indicates the achievement and maintenance of established levels of knowledge and clinical skills in a specified field and is absolutely required for this level of care and treatment.**

- **Section 715.6 Physician staffing. Hamilton Health Center employs both midlevel practitioners and physicians to provide health care services. Midlevel practitioners supplement physicians and allow physicians to focus on higher-acuity patients. Midlevel practitioners give physicals, write prescriptions, order tests, manage minor illness and educate patients. Individuals with substance abuse disorders present with very complex co-morbidities that require a higher level of skill and ability than a midlevel practitioner can provide.**

- **Section 715.7 Dispensing or administering staffing. The proposed 1/200 ratio for automated dispensing systems is adequate. Increasing the ratio would increase the possibility of errors and decrease the ability of the licensed person to observe and supervise the patients as required.**

- **Section 715.18 Rehabilitation services. In providing services to long-term rehabilitated patients, the social, political, economic and cultural context within which addiction and substance abuse exists including the risk and resiliency factors must be continually addressed. Understanding the addictive process and the potential for relapse, the need for continuing care and support for individuals with substance abuse disorders is absolutely necessary.**

- **Section 715.21 Patient termination. Refusing to provide services due to inability to pay is an unacceptable reason to terminate treatment. Programs should establish intake procedures that allow providers to screen for financial liability to determine if an individual with substance abuse is capable of paying for their treatment before entry into the program.**

- **Section 715.24 Narcotic detoxification. Narcotic detoxification requires supervision to ensure mental and physical health and welfare. Narcotic treatment programs should have a 7-day-per-week operating schedule not only for detoxification of patients but also for patients newly admitted to the program. Newly admitted patients are too unstable and unpredictable to be given take-home medication, increasing the possibility of diversion.**

- **Section 715.25 Prohibition of medication units. The need for counseling and support services when receiving medication is absolutely necessary to obtain and maintain effective recovery. Medication units do not address the addictive process. By only administering medication and not addressing the underlying issues causing the addiction, the issues are only masked and not resolved.**

Hamilton Health Center is hopeful these comments are helpful in developing and implementing standards and guidelines that will provide a comprehensive continuum of care to individuals with substance abuse disorders. If I can be of further assistance, please do not hesitate to call me at 717-230-3942.

Sincerely,

Karen Wilson BSN, MHA
Director of Nursing and Behavioral Health

Original: 2134

ESPER TREATMENT CENTER

••• An Opiate Treatment Program

September 9, 2002

Mr. Robert Nyce
Executive Director
IRRC
333 Market St. 14th Floor
Harrisburg, PA 17101

Dear Mr. Nyce:

I am voicing my support for the final-form Standards for Approval of Narcotic Treatment Programs submitted to the Independent Regulatory Review Commission (IRRC) on August 20, 2002.

If you have any questions, please feel free to call me at (814) 459-0817.

Sincerely,

Dr. James Esper
Project Director
Esper Treatment Center

JE/ja

25 West 18th Street
Erie, PA 16501
Phone (814) 459-0817
Fax (814) 455-2371

ESPER TREATMENT CENTER

••• An Opiate Treatment Program

Original: 2134

September 9, 2002

Mr. Robert Nyce
Executive Director
IRRC
333 Market St. 14th Floor
Harrisburg, PA 17101

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Sincerely,

John Applebee, CAC/CCS

John Applebee, CAC/CCS
Clinical Director/Clinical Supervisor
Esper Treatment Center

JA/ja

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