The UNIVERSITY of VERMONT

Vermont Legislative Research Shop

Methadone Maintenance Programs and the Treatment of Heroin Addiction

Heroin use statistics in Vermont

In 1998 substance abuse treatment centers in Vermont admitted 353 patients for treatment who reported heroin as a problem. Of these, 214 reported heroin as the primary drug used. See figure 1 (VT Dept. of Health, 1998). That represents a 50 per cent increase since 1997. It should be noted that this trend parallels an increase in treatment sought for all substance abuse problems (see figure 2).

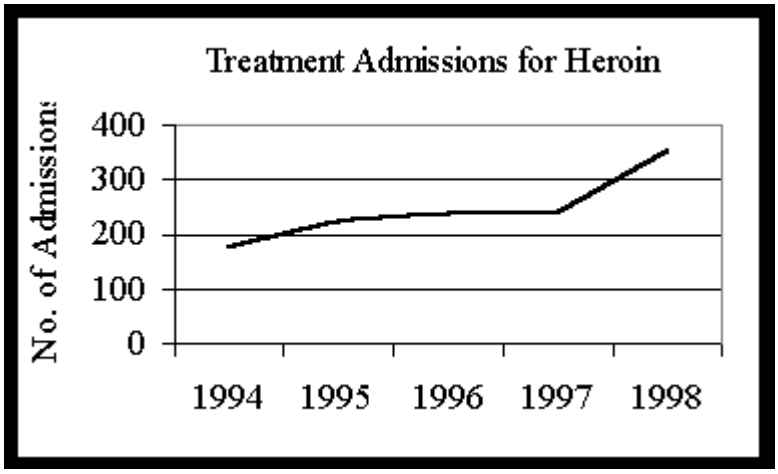

Figure 1: The numbers reflect total patient reports stating heroin as a problem. Numbers are taken from the annual Statistical Reports of the Office of Alcohol and Drug Abuse Programs, 1998.

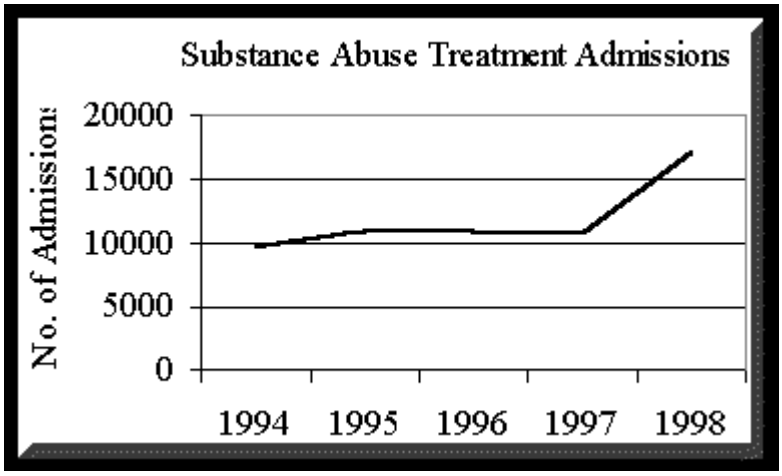

Figure 2: Total reports across **all** substances (heroin included) and all problem levels. Numbers are taken from the annual Statistical Reports of the Office of Alcohol and Drug Abuse Programs, 1998.

What are the current treatment options available for heroin addiction in Vermont?

The State of Vermont contracts with treatment providers for substance abuse treatment. There are three levels of treatment available: outpatient, intensive outpatient, and residential. Outpatient treatment combines individual counseling, group counseling, family counseling, and self-help meetings such as AA. Clients meet with counselors an average of 1or 2 times a week. Intensive outpatient clients meet with counselors 3 to 4 hours per day, 3 to 4 days per week. It is an alternative for patients who cannot afford residential care due to job or family obligations. Residential care treatment is highly structured and takes place in a residential facility, for up to 21 days for adults and 90 days for adolescents (VT Dept. of Health, 1996).

What are the advantages of clinic-based methadone treatment?

Methadone is a synthetic oral narcotic that works like morphine to suppress withdrawal symptoms among opioid addicts (primarily heroin). It does not produce euphoria, rather it blocks the euphoria associated with other opioid drugs, i.e. preparations or derivatives of opium. It does, however produce dependence (Farley, 1994).

Studies have found methadone maintenance programs are more effective than drug-free treatment in that they reduce: (1) illicit opiate use; (2) the risk of acquiring HIV associated with injection and ; (3) criminal activity (Farrell *et al*., 1994). The reduction in drug use and crime are directly related to the length of time in the program (Farrell e*t al*., 1994). "Patients stay in [methadone] maintenance programs at a rate two-and-a-half times that of patients in self-help residential programs, and five times that of patients in drug-free outpatient programs" (Farley, 1994). Also according to Farrell *et al*., better treatment outcomes are achieved with better support services. And while treatment is costly, it is "substantially cheaper than the cost to the community of the active or incarcerated drug user" (Farrell *et al*., 1994).

What are the disadvantages of methadone clinics?

Approximately one quarter of patients continue to inject heroin during treatment, "even in the most effective programs." In addition, relapse rates are 70% for patients after leaving treatment. There is also concern that take-home doses of methadone are sold rather than consumed, encouraging strict regulation of clinics (Farrell et. al., 1994). Some deaths have occurred during initiation of methadone maintenance, when tolerance is incorrectly assessed, and during maintenance when several days' doses are combined. Those responsible for maintenance programs are often not in a position to monitor increased mortality in the community (Harding, 1993).

What is the relationship between heroin use, HIV, and methadone therapy?

The relationship between heroine use through needle injection and contraction of the HIV virus is important to consider. Because patients are receiving controlled methadone treatment the risk of users being infected by HIV through injection is reduced (Harding, 1993).

Also important to consider are the effects of methadone on patients already infected with HIV. According to researchers at Yale University and VA Healthcare System in West Haven, Connecticut, HIV-positive patients who are simultaneously receiving methadone treatment and the AIDS drug *zidovudine* may be at risk of high level exposure of zidovudine and subsequent side effects (McCance-Katz, 1998).

Are there alternative methadone treatment settings?

Primary care-based opioid maintenance treatment (as opposed to clinic treatment) may improve access to treatment. Properly trained clinicians could offer this treatment to their patients. This approach also offers the possibility of opioid maintenance treatment in communities, such as smaller towns, where methadone maintenance programs are not available. Traditional primary care settings may avoid some of the negative aspects of opioid maintenance programs, including the interactions with patients who continue to use illicit drugs and the stigma associated with drug treatment settings. Primary care settings also allow patients to receive drug treatment services and primary medical care under one roof (O'Connor et. al., 1998). The primary care approach has exhibited high retention rates and reduction in illicit drug use, comparable to "optimal methadone [maintenance] programs" (Farrell et. al., 1994).

Are there alternative treatment drugs available?

Levo-alpha-acetyl-methadol, also known as Orlaam or LAAM, was approved in 1994 for opioid treatment works much like methadone, but its effects have a longer duration, 48 to 72 hours, versus 24 hours for methadone. This reduces the required visits, allowing more patients and permitting patients the chance to lead a more normal life. Take-home dosing is not permitted with LAAM due to the risk of overdose (Farley, 1994).

Buprenophrine, a new alternative to methadone for maintenance treatment of opioid dependence, may have important advantages compared with methadone as it is easier to withdraw from and less likely to cause overdose (O'Connor et. al., 1998).

What is the Clinton administration's position on methadone treatment?

The administration wants to reduce "unnecessarily stringent government regulations" to improve access to methadone treatment. It would also set up training and accreditation programs for physicians, to improve access in rural and suburban settings (McCarthy, 1998).

What help is available to states from the Federal government?

The Center for Substance Abuse Treatment (CSAT), housed in the Department of Health and Human Services, provides technical assistance, training and financial support to states and communities as well as their "TIPs" or Treatment Improvement Protocols. Another project educates judges about the use of treatment programs as alternative sentencing for crimes related to heroin or other drugs (Farley, 1994). CSAT also helped Arkansas open its first program and Texas was another state that requested assistance to remedy problems with its treatment centers-both the FDA and the DEA were involved in a conference with state officials. (Farley, 1994).

References

Farley, Dixie. 1994. "New Drug Approval Approach Boosts Fight Against Heroin Addiction." http://www.verity.fda.gov/search97cgi/s9…rt%3D1%26ResultCount%3D10&hlnavigate=ALL, U.S. Food and Drug Administration, November, 1994.

Farrell, Michael et. al. 1994. "Methadone maintenance treatment in opiate dependence: a review," *British Medical Journal* 309: 997-1001.

Harding-Pink, Deborah. 1993. "Opioid Toxicity, Methadone: one person's maintenance dose is another's poison," *Lancet* 341 (March 13):665-666.

McCance-Katz et. al. 1998. "Methadone Effects on Zidovudine Disposition (AIDS Clinical Trials Group 262)," *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 18 (Aug. 15):435-442.

McCarthy, Michael. 1998. "Clinton administration plans to expand access to methadone," *Lancet* Oct. 10: 1206.

O'Connor, Patrick G. et. al. 1998. "A Randomized Trial of Buprenorphine Maintenance for Heroin Dependence in a Primary Care Clinic for Substance Users versus a Methadone Clinic," *American Journal of Medicine* 105:100-105.

Vermont Department of Health Office of Alcohol and Drug Abuse Programs. 1998. *Annual Statistical Reports of the Office of Alcohol and Drug Abuse Programs*, Burlington, VT.

Vermont Department of Health Office of Alcohol and Drug Abuse Programs. 1996. *Treatment Admissions Data Report*.

Completed by Molly Hooker, Lucinda Newman, and Jennifer Symmes on 9 February, 1999