

# Integrating the Methadone Patient in the Traditional Addiction Inpatient Rehabilitation Program — Problems and Solutions

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## Abstract

Physicians have reported alcoholism and opioid addiction as co-morbid conditions since the 19th century. From the inception of methadone maintenance treatment, heroin addicts with serious alcohol conditions have enrolled in methadone maintenance programs.

Programs that treat alcoholism, including the traditional addiction inpatient rehabilitation programs of the Addiction Treatment Centers (ATCs) operated by New York State, have based their treatment regimen on 12-step abstinence models. Methadone maintenance was considered antithetical to this philosophy. It was regarded as simply substituting one drug for another and not a legitimate treatment for opiate dependence. Therefore, methadone patients were often not accepted into alcohol treatment programs, since they were perceived as active addicts taking a mood-altering drug.

Alcohol-related conditions among methadone patients are major causes of liver disease and death, and behavior problems associated with excessive drinking are major reasons for discharging patients. To address these issues and the lack of treatment facilities, the administration of the New York State Office of Alcoholism and Substance Abuse Services (OASAS), which licenses both methadone programs and the ATCs in New York State, realized that many of the methadone patients with alcohol problems are in need of the services provided at the ATCs. They instituted, therefore, a rigorous educational effort for the medical and counseling staffs of the ATCs, designed to integrate methadone treatment into the ATC treatment framework.

Eighty percent of the 220 methadone patients who entered the ATCs in a demonstration project during the 1997/1998 state fiscal year have been compliant with the treatment regimen. These results have led to acceptance of methadone patients into the ATCs.

**Key Words:** Alcoholism, opiate addiction, methadone maintenance treatment, 12-step programs, inpatient rehabilitation, staff attitudes.

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## Introduction

PHYSICIANS HAVE LONG BEEN AWARE that alcoholism and narcotics addiction often coexist. According to Green and Jaffe (1), physicians have reported the excessive use of alcohol by narcotic addicts since the late 19th century. Terry and Pellens (2) and Courtwright (3) indicate that iatrogenic addiction was common in the 19th century, and that the administration of narcotics to reduce or “cure” alcoholism was a factor in the development of opioid addiction.

Kolb (4), in a U.S. Public Health Service study implemented in the 1920s, reports that 39% of the 230 addicts surveyed nationwide were heavy users of alcohol prior to and/or

interchangeably with their addiction to narcotics. Pescor (5) reported similar findings a decade later: 37.4% of the 1,036 narcotic addicts admitted in 1936 and 1937 to the U.S. Public Health Hospital in Lexington, Kentucky reported having had serious problems with alcoholism prior to their addictions to and during periods of abstinence from narcotics.

With the establishment of methadone maintenance treatment (MMT) in the late 1960s and early 1970s, alcoholism was recognized as a serious health problem among methadone patients. Kreek (6, 7) found, in a prospective study, that at admission to MMT, 20% of 214 patients had serious alcohol problems and that health problems related to alcoholism were major causes of liver disease. In contrast, the estimated prevalence of alcohol abuse, and abuse and dependence problems among all adults over 18 years of age in the United States, is 7.41% (8).

In a study of outcomes of methadone treatment in the 1970s, Joseph and Appel (9) reported the following:

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- twenty-four percent (24%) of 1,428 randomly selected patients had serious alcohol problems;
- alcohol problems were the major factor in 26% of the 934 discharges from treatment;
- alcohol-related illnesses (e.g., cirrhosis) were the major causes of death for patients in treatment;
- alcohol-related illnesses were the second major cause of death, following narcotic overdose, for patients who left treatment;
- survival rates over a ten-year period were lower for patients who were considered alcoholic than for non-alcoholic patients (67% vs.87%); and
- programs for the treatment of alcoholism refused to accept methadone patients with alcohol abuse, and Alcoholics Anonymous did not admit methadone patients into its program.

Despite its approved use in the treatment of narcotic addiction in 1972 by the United States Food and Drug Administration (10) and favorable reviews as the most effective treatment for heroin addiction by the Institute of Medicine and the National Institute of Health, methadone maintenance remains a controversial approach among chemical dependence treatment professionals, public officials, policymakers, and the medical profession. There are those who believe that methadone maintenance is nothing more than a recognized substitute for opiate addiction and that it provides no clinical or rehabilitative benefit (11). In addition, the use of a maintenance medication for addiction appears to conflict with the philosophy of complete and total abstinence (11). Patients with a diagnosis of opiate dependence who are receiving MMT are often stigmatized; they have long been excluded from fully participating in AA meetings, and denied admission and treatment in traditional addiction and chemical dependence programs. Within the chemical dependence treatment system in New York State, the inpatient rehabilitation program was particularly resistant to providing medical and clinical addiction treatment to patients who were opiate dependent and maintained on methadone, while also addicted to alcohol and/or other drugs.

To more appropriately serve this special population, in 1996 the New York State Office of Alcoholism and Substance Abuse Services developed a pilot program to treat methadone-

maintained patients with alcohol problems in their inpatient addiction-treatment system. In 1997, 220 patients with alcohol problems were recruited from methadone maintenance programs to enter the Addiction Treatment Centers (ATCs).

### **Patient Profile**

The profile of the methadone-maintained patient is similar to that of the patient traditionally found in the inpatient alcohol rehabilitation program. The presentation is one of a polysubstance user of alcohol, heroin, cocaine, crack, or cannabis with mental health problems and social problems such as transient housing, homelessness and criminal activity. Also, patients present serious medical problems, including liver disease, heart disease, tuberculosis, hepatitis and HIV. Mental health diagnoses are frequently encountered. For example, high rates of depression with prevalence rates approaching 17% have been reported for methadone-maintained patients (12, 13). However, in the population of methadone-maintained patients treated in the ATCs, depression was seen in 24% and anxiety disorders in 20%. In addition to emotional disorders, serious social problems affecting the patients included homelessness, alienated families, criminal behaviors, unemployment, and financial problems.

Despite these problems, methadone-maintained patients who are admitted into the ATCs do exceptionally well in treatment, with 80% of the 220 admissions in the pilot study referred to above completing the goals of their treatment plan and successfully returning to their outpatient methadone treatment programs after discharge. However, the patients who are selected by a methadone treatment program for referral to an ATC are probably among the most motivated and therefore are most likely to succeed. The ongoing support that is offered through the referring methadone treatment program contributes to their clinical success.

### **Changing the Organizational Culture**

Within the standard addiction inpatient rehabilitation program, treatment of methadone-maintained patients will only be successful if staff attitudes and expectations are addressed. Long-held misconceptions and biases by staff about methadone, patients on methadone maintenance, and MMT itself, have

to be changed in order for the methadone-maintained patient to be integrated into the traditional programs of the ATCs. As described by Gordis (11), a philosophy existed in the ATCs that supported the mistaken notion that methadone, when used as a maintenance medication, was a mood-altering drug and a substitute narcotic prescribed for the purpose of reducing criminal drug-seeking behavior. Methadone was not perceived as a legitimate medication for opioid addiction. Therefore, patients maintained on methadone were often treated as unmotivated and unworthy of clinical intervention, and their treatment was perceived as solely ingesting the "drug." To offset misinformation and bias against methadone by the staffs of the ATCs, OASAS instituted an educational program about the proven efficacy of methadone as a legitimate medication to treat addiction.

In order to ensure that methadone patients in the ATCs have the maximum opportunity for success, methadone programs had to expand the number and types of treatment interventions they provide, including such services as biopsychosocial assessments, level of care determinations, and a full diagnostic work-up. The referring methadone clinic had to enter into a collaborative relationship with the ATC and ensure that treatment plans made for the patient in the ATC continued when the patient returned to the referring methadone program. Conversely, the methadone program had to be assured that the patient would be maintained on methadone without experiencing bias from the ATC staff, and that the patient would not be arbitrarily detoxified from methadone in the inpatient ATC program. Once the patient returned to the methadone program after completing the ATC program, the staff of the methadone clinic had to monitor alcohol and other chemical drug abuse issues and confront noncompliance by the patient with program rules and regulations. Structural and programmatic changes required by the increased collaboration between the methadone program and the ATC include regular medical and clinical consultations, multi-agency case conferences about the patients, and development of compatible treatment policies.

The methadone patients who are referred for addiction treatment, their families and the staffs of the referring methadone programs must be knowledgeable about the rules and regulations of the ATCs and must be assured that the patients are entering a safe environment. This environment must be one in

which all patient rights are protected, confidentiality is respected, and chemical abuse issues will be addressed in a therapeutic, open and honest fashion.

Program administrators in the ATCs must be alert to an unintentional establishment of a class system within the patient population by the development of separate tracks for methadone-maintained patients. To offset this possibility, the administrators developed clinical programs that encouraged group cohesion among all patients by emphasizing their strengths, weaknesses, and experiences, and the stigma and discrimination they all may encounter.

The methadone patient's motivation for treatment can be measured, like all other chemically dependent patients' motivations, by a willingness to consider behavioral changes and by an agreement to participate fully in the inpatient addiction-treatment program. As with other admissions to the ATC, the first several days to a week are critical to developing positive expectations from treatment, stabilizing the level of motivation, and establishing an environment of acceptance, professional competence and safety.

To more fully integrate methadone patients into the ATC, it is necessary to have the organization deal systemically with chemical dependence treatment, thus treating methadone as a medication. We also suggest the following organizational strategies:

- Utilizing a team approach in the treatment of the patient. This has resulted in the highest levels of retention and completion of treatment as well as the highest degree of patient satisfaction. The treatment team should consist of a physician, nurse, addiction counselor, activity therapist, and case manager from the methadone treatment program.
- Group supervision, case conferencing and educational opportunities for the staff. These are designed to provide intense peer supervision and specific training for program interventions.
- In-service lectures and training by staffs of the ATCs and the MMTs to develop an integrated approach to the treatment of methadone patients with alcohol problems.
- Visits to MMT programs by staff of ATCs and visits to the inpatient programs of the ATCs by staff of the MMT programs. The purpose of these visits is to ensure that all personnel involved in the treatment of

methadone patients with alcohol problems are knowledgeable about the treatment environments, regulations and policies of all institutions that are involved in the planning and implementation of treatment.

- Team meetings and collaborative case conferences that include staff of both the ATC and the MMT program. Also, aftercare planning must be a collaborative effort because of the discrimination that methadone patients face, which results in a lack of access to safe and drug-free housing, employment, and other needed services.

For the state-operated ATCs, methadone became accessible through the on-site pharmacies operated by the State Office of Mental Health (in the same way that any prescription medication would be accessed for the ATC patients). The Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA), granted permission to these on-site pharmacies to provide methadone to patients under existing FDA and DEA regulations. Prior to the implementation of FDA and DEA approval, access to the medication required having the patients' referring methadone treatment program or the staff of the ATC physically transport the medication from the methadone program to the ATC on a daily or weekly basis.

### **Staff Attitudes, Values, and Beliefs**

A number of chemically dependent patients enter inpatient units of ATCs while also taking medications prescribed for a variety of medical problems. These medications do not interfere with the patient's interactions with staff and other patients. "Looking high" or complaining of fatigue is sometimes seen as an adverse reaction to many medications. Altered moods and affects such as tranquilization or fatigue may be observed with dually diagnosed patients who take both antidepressants and anti-psychotics. Yet, the dually diagnosed patient on antidepressants or tranquilizers is accepted by the treatment staff of the addiction treatment centers without the bias that is directed toward the methadone patient.

As with any change, staff attitudes and their philosophical and behavioral expectations come to the forefront quickly. Gordis (11) reports that in alcohol treatment programs, staff may not consider MMT to be an acceptable

treatment for heroin addicts and, therefore, deny methadone patients with alcohol problems admission into treatment. Furthermore, staff who have personal histories of chemical dependence and are in recovery themselves may favor the total abstinence model that precludes the prescription of medications such as methadone. Criticism, discrimination, and shame are not part of the 12-step philosophy, and it must be made clear to staff and patients that this attitude has no place in the inpatient program. With the intensive training that has been described, methadone patients now have access to treatment without fear of ostracism or bias in an inpatient addiction-treatment center program, if that level of care is needed.

Family involvement, education and communication are important for all patients, and especially so for methadone patients. Their families and significant others must understand not only the addiction, but also the use of methadone as a medication for the treatment of the addiction (14).

Administrative, clinical and medical staff must be informed that methadone-maintained patients have lowered thresholds of pain tolerance, and that certain pain relievers with narcotic antagonist properties do not work for them (15). Training clinical and medical staff in various alternatives for pain management is critical for patient comfort and retention. The need for immediate pain relief provides a considerable challenge for the medical staff. The patient can present with symptoms that far exceed the usual level of pain seen in most other patients. The need for immediate relief, and the stress related to this need, must be addressed in an educational, sensitive climate. When the patient's anxieties and fears are addressed, less medication can frequently be given. There is a great need for both patients and staff to learn and practice various options for pain management, coping with frustration, and relaxation techniques.

The physician and nursing staff must continually reassess the appropriate dosage of methadone to ensure the best chance of clinical success. Too often, patients admitted to the inpatient program are undermedicated prior to admission because they were abusing alcohol and other drugs and were not compliant with the treatment regimen. While methadone blood levels can be very helpful in this assessment, they are not needed for every patient. The levels are most helpful with unexplained requests for higher or lower doses by the

patient, or to rule out drug interactions. The methadone maintenance program must be kept abreast of new patient information and be actively involved in the decision process when a dosage change is considered.

### Conclusions

Methadone maintenance is a medically sound treatment intervention that has demonstrated efficacy in controlling drug craving; it has saved hundreds of thousands of lives (16). In 1996, OASAS made a very deliberate decision to change the policies of the ATCs to admit for treatment methadone patients with alcohol problems. Among methadone patients, alcohol is a major reason for discharge from treatment, because of behavior problems. It is also a major cause of liver disease and death. Furthermore, programs that treated alcoholism had previously refused to admit methadone patients, since methadone had not been fully accepted as a treatment for addiction. OASAS's decision resulted in the development of an educational program for the treatment staff of the ATCs; this program teaches about the efficacy of methadone in the treatment of addiction, changes in clinical programming, and collaborative relationships between MMT programs and the ATCs.

A pilot program implemented in 1997 resulted in the admission of 220 methadone patients into ATCs. About 80% of the methadone patients complied with the ATC program and completed treatment. As a result of this favorable outcome and the education provided to staff, methadone patients are now being treated for alcoholism in the ATCs, and methadone treatment is provided on the premises.

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