Medication Assisted Treatment:
Utilizing Methadone and Counseling
Learning Objectives

• Will understand of the induction process for Methadone treatment.

• Will gain an understanding of the Harm Reduction Model Philosophy

• Will be able to list the key elements involved in the therapeutic relationship and gain an understanding of how counseling is integrated in Medication-Assisted Treatment
Induction Process
Medication Management
Addiction Is A Disease

• Substance dependence is a chronic, treatable brain disease.
• Substance dependence is recognized by the medical profession:
  • American Medical Association
  • World Health Organization
  • National institute of Health
• We now know that addiction is not a personality disorder. It is a progressive disease; if left untreated; it will get worse.
Addiction Is A Disease

- Chronic (long, indefinite duration)
- Progressive (untreated, it is not a static disorder)
- Relapsing (return to use of addictive drug)
- Incurable (… but treatable)
- Fatal (high mortality in untreated and mistreated)
Goals For Pharmacotherapy

• Reduction and prevention of withdrawal symptoms
• Reduction and prevention of drug craving
• Prevention of relapse to use of addictive drug
• Restoration to or toward normalcy of any physiological function disrupted by drug abuse
Profile For Potential Psychotherapeutic Agent (Methadone)

- Effective after oral administration 80%-95% bioavailable compared with only 30% for oral morphine
- Long biological half-life (>24 hours)
- Minimal side effects during chronic administration
- Safe
- Efficacious for a substantial % of persons with the disorder
Methadone Treatment has a Positive Impact in Three Areas:

• Crime Rate
• Public Health
• Socioeconomic status
Time Incarcerated

- One year before treatment: 31.70%
- One year after treatment: 6.70%
18 Month HIV Seroconversion by Methadone Maintenance Treatment Retention

Metzger et al., 1993
Employment Before and After Treatment

N=895
BEFORE INITIAL DOSE…

• Eligible and appropriate for MMT?
• Current physical dependence / tolerance
• Objective evidence of withdrawal, observed and documented.
• H&P, UDS, consents, information, etc.
Development of Tolerance/Dependence

...loss of “on/off” condition

With continued and repeated use…

• Tolerance develops (increasing dose for desired effect)

• Physical dependence develops (Withdrawal syndrome on abrupt cessation or reduction in the dose of the drug)
Tolerant/Dependent Drug States

<table>
<thead>
<tr>
<th>Drug Effect Scale</th>
<th>Loaded</th>
<th>“High”</th>
<th>Normal Range</th>
<th>“comfort Zone”</th>
<th>“Sick”</th>
</tr>
</thead>
</table>

Time
Heroin Simulated 24 Hr. Dose/Response
With established heroin tolerance/dependence

- Loaded
- "High"
- Normal Range
  "comfort Zone"
- Subjective w/d
  "Sick"
- Objective w/d

Dose response

Time
Methadone Simulated 24 Hr. Dose/Response
At steady-state in tolerant patient
Medical Protocol
Early Induction

▪ The dosage can be increased per medical order if no relief is observed or reported during the time of peak levels of methadone.
▪ At such time that the patient is comfortable, even briefly, the dose for that day is held to equal the total dose for the previous day.
▪ Even temporary relief of w/d signs and symptoms indicate that methadone levels have reached the therapeutic level or comfort zone. We know that peak serum methadone levels will increase significantly over that next 2-3 days, with no increase in dose, as steady-state is achieved.
▪ When the absence of withdrawal signs and symptoms indicate that relief is lasting for 24 hours this marks the end of the early induction phase.
Induction Simulation — Low to Moderate Tolerance

Therapeutic Window

Days/Half-Lives ⚫ =Dose Increase
Medical Protocol
Early Induction

**A Road-Map to “Steady State”**

- **High**
- **Comfort Zone**
- **Sick**

**Methadone dose levels**

- ng/ml

**Days/Half-Lives**
- Methadone half-life = 24-36 hours
- Dose constant at 30 mg daily. Interdose interval = 24 hrs (trough to trough)
- Peak levels increase daily for 5-6 days with **NO increase in dose!**
QUESTIONS?
Harm Reduction Model/Therapeutic Relationship

The Philosophy Behind the Model as it Relates to MAT
Harm Reduction Model

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.

- Non-judgemental
- Non-punitive
- Not hinged on abstinence
- User driven
Medication Assisted Treatment and Harm Reduction

**Increases**

↑ Retention in treatment

↑ Engagement in socially productive roles

↑ Employability

↑ Patient health outcomes

**Decreases**

↓ Impulsive substance abuse behaviors

↓ Mortality rates

↓ Criminal activity

↓ Transmitted diseases (HIV/Hep C)
Benefits of a Harm Reduction Approach:

- In 2012, OTPs had more than quadruple the percentages of testing services compared to non-OTPs for infectious diseases.
- Increased testing = earlier detection
- Earlier detection = earlier treatment
- Decreases spread of disease

Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012.
Benefits of Harm Reduction and MAT

MAT

• Decreases impulsive substance behaviors
• Decreases deaths
• Decreases criminal activity
• Increases retention in treatment
• Increases engagement in socially productive roles
• Increases employability
• Decreases overall chaos
• Helps to develop structure
• Decreases HIV/HepC transmission

In short – MAT can help improve overall function and patient living a ‘normal’ and productive life
Your Role as a Staff Member

1. Encourage, and Reflect. Refrain from using word choices and actions that may produce feelings of shame, or guilt to elicit change.
2. Focus on the functioning of a patient as a whole.
3. Recognize steps to change in all areas of their lives, not just chemical dependency.
4. Celebrate the patients successes...no matter how small
5. Understand your own biases. What you deem successful may not be the same as what the patient deems successful.
6. Do not fault them for trying to make changes, even if they fail.
7. Be empathetic.
8. Remind yourself that if they are doing less harm to themselves than they were yesterday, then the goal has been achieved.
9. Do not be punitive or use shame as a focus for change.
Empowerment

- Encouraging the person to identify safety risks.
- Offer resources to reduce or eliminate these risks.
- Provide support during this process.
- Build confidence rather than perpetuating shame.
- Practice acceptance of their right to make their own choices.
The Power of Language

<table>
<thead>
<tr>
<th>Commonly used term</th>
<th>Alternate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean</td>
<td>Negative; free of illicit substances</td>
</tr>
<tr>
<td>Dirty</td>
<td>Positive; active use</td>
</tr>
<tr>
<td>Drug seeker</td>
<td>Relief seeking</td>
</tr>
<tr>
<td>Recreational</td>
<td>Non medical use</td>
</tr>
<tr>
<td>Replacement</td>
<td>MAT-Medication Assisted Treatment</td>
</tr>
</tbody>
</table>
Support

• Offer to make calls to schedule appointments with and/or for patients.

• Help patients call providers and plan realistic appointment times.

• For patients who do not have health insurance and are eligible for Medicaid or other public insurance it can be helpful to help guide them through the process.
Duration of Treatment

Recovery is a long term process.

- Depends on patient problems/ needs
- Less than 90 days is of limited/no effectiveness for residential/outpatient setting
- A minimum of 12 months is required for methadone maintenance
- Longer treatment is often indicated

Source: National Institute on Drug Abuse (NIDA)
Our goal is to Reduce the Risk of Harm to our Clients

- The detrimental consequences of leaving methadone treatment are dramatically indicated by greatly increased death rates following discharge.

- Until more is learned about how to improve post-detoxification outcomes for methadone patients, treatment providers should be very cautious about imposing structural barriers that discourage or impede long-term opiate replacement therapy.
How do we measure patient progress?
How Not to Measure Progress

- Do not measure progress by UDS only
- Do not measure progress by attendance only
- Do not measure progress by participation only
- Do not focus on what the patient has not done, but what the patient has done.
Key Elements to the Therapeutic Relationship

7 Key Components to the Therapeutic Relationship:

1. Presence of Trust
   a. Developed over time

2. Sincerity
   a. Consistency and sincerity solidifies the relationship.

3. Common Goals
   a. Healthy for patients and therapists to have common goals.

4. Humor
5. Accessibility
   b. Affects a patient’s progress in their treatment

6. Empathy and Unconditional Acceptance of the Individual
   a. A patient’s experience is part of them.

7. Expertise
   a. Flexibility in the treatment approach
QUESTIONS?
Citations:

- International Harm Reduction Association (trading as Harm Reduction International). Article “What is Harm Reduction?”
- Jessica Fillette-Hughes, Regional Director for South Florida at Colonial Management Group, LP.