

Treatment Practitioner's **Research Bulletin**

Alcohol and drug research treatment advances and best practice summary

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TREATMENT PRACTITIONER'S RESEARCH BULLETIN

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Does Methadone Treatment Change Alcohol Consumption?

Unhealthy alcohol use is common among patients receiving methadone treatment. The effect of such treatment on alcohol consumption, however, is not clearly understood. Therefore, researchers reviewed and summarized the findings of 15 relevant studies.

- Nine studies found no change in alcohol consumption after the start of or during methadone treatment. Three studies found an increase in alcohol consumption, while another 3 reported a decrease.
- The studies that found no change or a decrease in alcohol consumption had better methods (e.g., some were randomized and controlled) than the studies that found an increase in alcohol consumption.

Comments by Tommie Ann Bower, MA:

This review clarifies that alcohol use generally continues during methadone treatment. Clinical teams in methadone treatment programs are encouraged to randomly screen for alcohol use. Teams should provide information on the impact of alcohol on health, social functioning, and relapse as part of patient education. In some cases, they may also need to examine patient attitudes toward alcohol, looking for and addressing minimization.

Reference:

Srivastava A, Kahan M, Ross S. The effect of methadone maintenance treatment on alcohol consumption: A systematic review. *J Subst Abuse Treat.* 007;doi:10.1016/j.jsat.2007.04.001.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

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Who Receives Office-Based Buprenorphine Treatment?

Buprenorphine treatment for opioid dependence has been provided in office-based settings in the United States for several years now. However, little is known about the patients receiving buprenorphine in these settings. Therefore, researchers conducted this study of 86 patients receiving the opioid treatment from 6 office-based physicians (all with at least 1 board certification in psychiatry or addiction psychiatry, or a specialty in addiction treatment) in New York City. Most subjects were white and had a job, housing, and support (financial and emotional); 41% had not been in previous treatment or participated in 12-step groups.

- According to a review of patient's medical records, 50% were misusing a prescription opioid at intake and 35% were using heroin; 9% were both misusing a prescription opioid and using heroin. The remaining subjects were either transferring from other treatment, had cravings, or had fear of relapse.
- Almost 50% reported using non-opioid drugs (e.g., cocaine, marijuana) at intake.
- Sixty-three percent of patients received prescriptions for at least 1 psychiatric medication during buprenorphine treatment.
- Time in buprenorphine treatment ranged from <1 to 30 months (median 8 months).
- According to the last entry in the medical record, 24% were misusing any substance and 8% were misusing opioids. Fifty-two percent were still receiving buprenorphine from the physician they saw at intake.
 - Factors associated with retention in buprenorphine treatment included full-time employment or other forms of support, stable housing, and prescription opioid misuse at intake. Psychiatric disorders or substance misuse during treatment did not affect retention.

Comments by Michael G. Boyle, MA:

These results are difficult to generalize. Physicians were mental health or addiction specialists (rather than primary care physicians), and subjects differed markedly from those who seek treatment from publicly funded, community-based treatment institutions. Further, most subjects had significant "recovery capital" and may not have been enmeshed in a culture of addiction.

More studies of buprenorphine treatment models among populations with differing characteristics are needed. However, this study suggests that office-based buprenorphine treatment is an attractive and effective option for people with opiate problems who would otherwise avoid treatment via the traditional system (because, as the authors note, of stigma associated with methadone and the necessity of daily attendance at a clinic for dosing in the early stage of treatment).

Reference:

Magura S, Lee SJ, Salsitz EA, et al. Outcomes of buprenorphine maintenance in office-based practice. *J Addict Dis.* 2007;26(2):13–23.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

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Do Behavioral Strategies Help Pregnant Women With Drug Dependence Stay in Treatment?

Pregnant women with drug dependence have historically poor attendance in treatment and high treatment drop-out rates. This study examined whether behavioral incentives, specifically escalating monetary vouchers, integrated into an ongoing substance abuse treatment program could enhance treatment participation and retention in these women.

Researchers randomized 91 pregnant women in treatment for opiate and/or cocaine dependence (7-day residential program followed by a 7-day intensive outpatient program) to receive vouchers that increased in value for each full day of counseling completed or no vouchers (control group). Most subjects were African American (84%) with an average age of 30.

- Retention and length of stay in residential treatment (first 7 days) was not affected by vouchers.
- During residential treatment, a little over one-third of both groups left against medical advice. Most who left did so within the first 2 days of care.
- Of the remaining women, those in the voucher group stayed in treatment longer (average of 11 days versus 9 days for the control group) and were more likely to attend treatment consistently (i.e., for 12 to 14 full days) (46% versus 16%).
- During the 30-day follow-up period, women who consistently (versus inconsistently) attended treatment stayed in treatment longer (25 days versus 18 days).

Comments by Norma Finkelstein, Ph.D., LICSW:

There is a critical need to develop better policies, programs, and treatment tools to prevent early treatment drop-out and to retain pregnant women in substance abuse treatment. These findings suggest that while behavioral incentives, such as monetary vouchers, might help improve some aspects of treatment attendance, they do not affect early drop-out or retention in later treatment. Therefore, it is worth examining whether addressing other variables, such as co-occurring psychiatric or medical disorders, trauma history, and/or family support might be more critical in preventing early treatment drop-out.

Reference:

Svikis DS, Silverman K, Haug NA, et al. Behavioral strategies to improve treatment participation and retention by pregnant drug-dependent women. *Subst Use Misuse*. 2007;42(10):1527–1535.

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Drug Use in Young Adulthood May Lead to a Decline in Health Later

Self-rated general health is strongly associated with important health outcomes, such as mortality. Researchers studied the relationship between self-reported drug use at baseline (the start of the study) and self-rated general health 15 years later among 3124 subjects. At baseline, subjects were from 4 U.S. cities, aged 20–32 years, and reported “good” or “excellent” health.

- At baseline, 812 subjects had never used illicit drugs, 1554 had used drugs in the past but not currently, 503 used marijuana only, and 255 used hard drugs (cocaine, amphetamines, opiates).
- Hard drug use at baseline was associated with health decline (report of “fair” or “poor” health) at follow-up.
- Cigarette smoking predicted health decline, even when other factors were accounted for, and weakened the effect of hard drug use at baseline.
- Marijuana use and past drug use at baseline did not have a statistically significant association with health decline at follow-up.

Comments by Michael Levy, Ph.D.:

The most interesting finding in this study is the relationship between cigarette smoking and health decline. While most everyone knows that cigarette smoking has serious health implications and is the leading cause of preventable death in this country, many addiction treatment professionals fail to address their client's smoking for various reasons. This study clearly demonstrates the relationship between cigarette smoking and health decline and, hopefully, this finding will reinforce the importance of addressing cigarette smoking while clients are in substance abuse treatment.

Comments by David A. Fiellin, MD, Co-Editor of Alcohol, Other Drugs, and Health: Current Evidence:

This cohort study demonstrates an association between drug use in young adulthood and a decline in self-reported health 15 years later. The investigators aptly noted that another addictive behavior, cigarette smoking, independently predicted health decline and may overshadow the effects of intermittent drug use. The study is limited by a lack of information on ongoing drug use behaviors over follow-up.

Reference:

Kertesz SG, Pletcher MJ, Safford M, et al. Illicit drug use in young adults and subsequent decline in general health: the Coronary Artery Risk Development in Young Adults (CARDIA) Study. *Drug Alcohol Depend.* 2007;88(2-3):224–233.

This summary and the physician's comments were adapted/reproduced from text previously published in Alcohol, Other Drugs, and Health: Current Evidence (www.aodhealth.org).

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Alcohol Use, Bone Density, and Hip Fractures in Older Adults

Moderate drinking has been consistently linked with higher bone mineral density but not the risk of hip fracture. Researchers in this study analyzed the effect of alcohol consumption on this risk. They used data from a study of 5865 older adults from 4 U.S. communities, 1567 of whom underwent a scan to assess bone mineral density.

- During about 12 years of follow-up, 412 hip fractures occurred.
- Light-to-moderate drinkers had a lower risk of hip fracture than abstainers while heavy drinkers had a higher risk. Results for men and women were similar.
- Bone mineral density (in the older adults who underwent scans) of both the total hip and femoral neck increased as alcohol use increased.

Comments by James Harrison, MHS, CADC:

When individuals aged 65 and older enter treatment for substance use disorders, they should be evaluated medically for risk factors, including heavy alcohol use, associated with hip fracture. Further, during annual physical examinations, ways to help these patients reduce hip fractures, including preventing falls, should be addressed.

Comments by Julia H. Arnsten, MD, MPH, Associate Editor of Alcohol, Other Drugs, and Health: Current Evidence:

Among older adults, alcohol consumption has a U-shaped relationship with hip fracture risk but a graded positive relationship with bone mineral density of the hip. This suggests that the higher hip fracture risk among heavier drinkers may be due to unmeasured, non-BMD factors. For example, this study did not directly examine fall incidence, which may have been associated with both alcohol consumption and hip fracture risk.

Reference:

Mukamal KJ, Robbins JA, Cauley JA, et al. Alcohol consumption, bone density, and hip fracture among older adults: the Cardiovascular Health Study. *Osteoporos Int.* 2007;18(5):593–602.

This summary and the physician's comments were adapted/reproduced from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

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Health Plans' Requirements for Mental Health and Substance Use Screening

Most health plans cover some treatment for mental health and substance use disorders, but too few people who need these services receive them. Limited requirements for screening and identification of these disorders partially explain this gap in treatment.

Researchers in this study assessed how many health plans required mental health and substance use screening in primary care. They looked at data from a survey of 434 health plans in 1999 and 368 health plans in 2003.

- The proportion of health plans that required screening for mental health or substance use disorders did not substantially change from 1999 (32%) to 2003 (34%).
- Of plans with a screening requirement, there was an increase in the proportion that required alcohol screening (from 33% in 1999 to 78% in 2003) and drug screening (from 8% to 78%).

Comments by Tom Delaney, MSW, MPA:

According to this article, only a minority of healthcare plans mandate screening, although the proportion of these plans requiring alcohol and drug screening is increasing. As screening in primary care becomes more common (partly because of increases in health plan requirements), counselors may find patients more willing to discuss their mental health and substance use. Given the stigma and denial associated with alcohol and drug use diseases, patients may disclose a history of their use more readily if the subject had already been broached by their primary care physician. A counselor, therefore, may be able to facilitate her discussions with patients by first asking if they have been screened by their physicians.

Comments by Peter D. Friedmann, MD, MPH, Associate Editor of *Alcohol, Other Drugs, and Health: Current Evidence*:

Health plan mandates and reimbursement for substance use screening would encourage primary care physicians to take a greater role in identifying, managing, and referring patients with substance use disorders. The finding that only one-third of health insurance products in 1999 and 2003 required screening for mental health or substance use disorders highlights missed opportunities to improve detection and intervention. Although tracking adherence to such a requirement might be challenging to insurers, the recent addition of procedure codes for substance use screening and brief intervention promises to provide a mechanism for reimbursement and monitoring in the future.

Reference:

Horgan CM, Garnick DW, Merrick EL, et al. Health plan requirements for mental health and substance use screening in primary care. *J Gen Intern Med.* 2007; 22(7):930–936.

This summary and the physician's comments were adapted/reproduced from text originally published in *Alcohol, Other Drugs, and Health: Current Evidence* (www.aodhealth.org).

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TREATMENT PRACTITIONER'S RESEARCH BULLETIN

Editorial Board

MEDICAL EDITOR

Richard Saitz, MD, MPH, FASAM, FACP

Professor of Medicine and Epidemiology

Boston University Schools of Medicine and Public Health, Boston, MA

At Boston University Medical Center, Dr. Saitz is a Professor of Medicine and Epidemiology, Associate Director of the Office of Clinical Research, Director of the Clinical Addiction, Research and Education Unit, Scientific Director of the NIH Youth Alcohol Prevention Center, and a primary care general internist and health services researcher. He is also Immediate Past President of the Association for Medical Education and Research in Substance Abuse. He mentors research trainees and is the associate director of the Boston University K30 clinical research training program.

ASSOCIATE EDITORS

Tommie Ann Bower, MA

Director of Program Development and Quality

Gosnold, Inc., Falmouth, MA

Tommie Ann Bower is the Director of Program Development and Quality at Gosnold on Cape Cod. Tommie has been running programs for many years. Beginning in 2005, she became a Process Improvement Coach with NIATx, and has coached on several other projects in Massachusetts and Maine. She is a Certified ARISE Interventionist and is currently working on creating a continuum of family services for Gosnold.

Michael G. Boyle, MA

President & CEO

Fayette Companies, Peoria, IL

Michael G. Boyle is President and CEO of Fayette Companies, a behavioral health management firm that provides comprehensive mental health and substance abuse services. Michael is the Director of the Behavioral Health Recovery Management project, serves as a coach to the State of Florida for the Robert Wood Johnson Foundation's Advancing Recovery project, is on the NASADA/NASMHPD National Task Force on Co-occurring Disorders, and is actively involved in the Network for the Improvement of Addiction Treatment and the American College of Mental Health Administration.

Tom Delaney, MSW, MPA

Executive Director

Boston Alcohol and Substance Abuse Programs, Inc., Boston, MA

Tom Delaney is the Executive Director of Boston Alcohol and Substance Abuse Programs, Inc., a non-profit outpatient clinic. He is the vice-president of the Massachusetts Organization for Addiction Recovery and chair of the DUI/Second Offender committee of the Mental Health and Substance Abuse Corporations of Massachusetts. Tom is a Massachusetts Licensed Certified Social Worker and a Licensed Alcohol and Drug Counselor (LADC I). He has a MPA in addition to his MSW degree from the State University of New York at Albany.

Norma Finkelstein, Ph.D., LICSW

Executive Director

Institute for Health and Recovery, Cambridge, MA

Norma Finkelstein is founder and Executive Director of the Institute for Health and Recovery, a statewide policy, program/systems development, training, services and research organization. Prior to this, Dr. Finkelstein was the founder and Executive Director of the

Women's Alcoholism Program/CASPAR, Inc., a comprehensive prevention, education, and treatment program for chemically dependent women and their families. She received her MSW from the University of Michigan and her Ph.D. from the Florence Heller School, Brandeis University.

James Harrison, MHS, CADC

Lancaster Site Director
Brandywine Counseling, Inc., Wilmington, DE

James Harrison, process improvement coach, serves as the Site Director for Brandywine Counseling's Opioid Treatment Program in Wilmington, Delaware, and oversees the agency's administrative and clinical services. He serves as the Change Leader for Brandywine Counseling, an early member of NIATx. A licensed and certified Drug and Alcohol Counselor, he holds a Master's in Human Services from Lincoln University in Pennsylvania.

Michael Levy, Ph.D.

Director of Clinical Treatment Services
CAB Health & Recovery Services, Inc., Peabody, MA

Michael Levy is the Director of Clinical Treatment Services at CAB Health & Recovery Services, Inc. He is a lecturer in psychiatry at the Cambridge Health Alliance and at Harvard Medical School, and he maintains a private practice in psychotherapy. He writes extensively on substance abuse and its treatment.

MANAGING EDITOR

Rosanne T. Guerriero, MPH

Boston Medical Center, Boston, MA

Rosanne Guerriero is the Managing Editor of *Alcohol, Other Drugs, and Health: Current Evidence*. She has extensive writing and editing experience and has produced substance abuse-related materials for a range of audiences, including doctors, treatment counselors, parents, and students. Rosanne also has implemented health education campaigns and facilitated community-based initiatives aimed at addressing substance use issues.

Contact Information:

Treatment Practitioner's Research Bulletin
Join Together
715 Albany Street, 580-3rd Floor
Boston, MA 02118
editor@jointogether.org

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