Response: Still Room to Improve an Effective Treatment

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We would greatly benefit from research on treating opioid-addicted individuals' chronic pain.

Warren Bickel: The paper provides a good general overview of the changes that have taken place in methadone treatment over the years. Its basic message is appropriate: Methadone treatment is effective and is being more widely accepted.

George Bigelow: Yes. I do think, though, that the paper overstates the extent to which methadone treatment has entered the medical mainstream. Mr. Marion's program is in New York City, where methadone has a longer history and more public support than many or most other places.

Bickel: I agree. The State of Vermont, for example, has one methadone clinic, which has a waiting list of over a hundred people. Here in Arkansas, we only have two methadone programs in the Little Rock area. This article serves as a reminder that methadone is effective, and therefore we need to do what we can to continue to bolster its acceptance by both the public and the medical and rehabilitation communities.

Kyle Kampman: Many programs still have difficulty recruiting for medical staff positions. And while there may be less stigma today, plenty still exists—not only against methadone and methadone patients, but also extending to physicians and psychiatrists who work with them.

Bigelow: Overall, nationwide, I don't think there is any other medication that is so effective and yet so hard to get as methadone.

Older patients, younger patients

Bigelow: Mr. Marion describes the aging of the methadone population, which of course is testimony to the effectiveness of the treatment. Methadone has significantly extended the life expectancy of opiate abusers. One corollary has been the creation of a group of patients with more concurrent medical disorders of the type that all aging populations have, such as hypertension and diabetes. Our group recently published a study on this issue and the challenges it will create for treatment providers [Lofwall et al., 2005].

Kampman: Partly because of the medical problems related to aging, and partly due to opioid abusers' high propensity for trauma, we see a lot of patients with pain. Many come to us through referrals from pain management specialists who are apprehensive about treating opiate-dependent patients. Chronic pain is a difficult problem to manage anywhere, and perhaps more so in a methadone clinic. We would greatly benefit from new research in this area.

Bickel: The larger number of new, young opioid-dependent patients speaks to the need to have multiple treatment options. It is not helpful to place a person who has recently become involved with prescription drugs in treatment with patients having extensive histories of drug dependence. We need to expand the range of options, so that different types of patients can receive appropriate treatments.

Bigelow: One respect in which our experience seems to differ from Mr. Marion's is the 60 percent figure he cites for treatable depression among methadone patients. That is considerably higher than we see in Baltimore. I can't think of a reason why there should be such a difference, except perhaps that Mr. Marion's figure reflects assessments made at intake. We find that many of our patients are depressed because of the difficulties of the opioid-abusing lifestyle, but their mood recovers once they are normalized on methadone.

Treatment models and settings

Bickel: I think it is very important to keep in mind that methadone is only one part of the larger treatment picture. The research agenda should include how we can best utilize both methadone and buprenorphine to provide a true continuum of care where every

patient receives treatment in an appropriate modality. The interesting questions in methadone research right now aren't about its efficacy as a pharmacological agent—that was established long ago. They are about the different ways of delivering methadone and how to best incorporate social and behavioral counseling in the treatment.

Bigelow: For example, Mr. Marion talks about methadone medical maintenance, where stabilized patients can transfer their visits from the clinic to a physician's office. I think we should keep striving to develop models like that, so that patients and physicians can have maximum flexibility in the choice of treatments as well as treatment settings.

Bickel: Tom McLellan's group [McLellan et al., 1993] examined the importance of counseling, medical care, and psychosocial services with respect to the outcomes of methadone patients. They concluded you could make methadone treatment outcomes look either horrible or successful based on the quantity and quality of accompanying psychosocial treatments.

Bigelow: I agree. The psychosocial and behavioral treatments that accompany the pharmacotherapies are critically important, if only because they can be applied to the full range of substance abuse disorders. The drawback of a medication such as methadone is that it is pharmacologically specific—it will only treat opioid addiction—whereas today's patients tend to be polydrug abusers.

Bickel: Our group has been looking at different ways of delivering psychotherapies. Recently we completed a trial where we compared the results of computer-delivered cognitive-behavioral treatment with the same treatment delivered by a therapist, along with a control treatment. So far, the results appear to show that the computer- and therapist-delivered treatments were better than the control, but not significantly different from each other, suggesting that we may be able to use computer technology to expand access to psychotherapies.

Bigelow: The NIDA Clinical Trials Network has conducted a study of the effectiveness of motivational incentives to reduce stimulant abuse in methadone clinics. Though the data are still in review, the incentives appear to have had a positive impact, as measured by the frequency of stimulant-negative urine samples during treatment. Another area where I think significant research is needed is the development of longer acting methadone dosage forms, which would make the medication more convenient while also reducing the risk of overdose and diversion. Unfortunately, I don't think anyone is looking into this. &

Psychosocial and behavioral treatments are critically important adjuncts to methadone therapy.

REFERENCES

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