

5 FIVE BOROUGH AIDS MENTAL HEALTH ALLIANCE

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The Use of Buprenorphine for Opiate Dependence: *Its Time Has Come!*

Submitted by: David M. McDowell, M.D.

Recent reports in the media have highlighted the fact that there is a growing problem with the use of opioids in the United States. Opioids, or opiates as they are commonly referred to, may be prescribed medicines, such as Vicodin or Oxycontin, or they may be drugs that are used illicitly, such as heroin. Recently, the FDA has approved a new option for the treatment of opioid dependence. Buprenorphine, now available in the United States, has some unique and remarkable properties that make it particularly helpful in the treatment of opioid dependence. It is found in the form of a small, hexagonal, orange (usually) pill that is taken sublingually (under the tongue). Buprenorphine has been used as a pain medication in hospitals in the U.S. for more than thirty years. In the year 2000, Congress relaxed the restrictions and permitted office-based prescribing to persons with opioid dependency. Buprenorphine became the first drug to qualify under the Congressional act when the FDA approved the medication for addiction treatment in 2002.

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**A Letter from the Editor:
Tim Hunt, CSW**

Greetings! This spring 2004 issue of the FAMHA newsletter focuses on a new drug that the FDA has recently made available for the treatment of opioid (heroin) dependency. The new drug called buprenorphine can be prescribed by qualified physicians. It offers an additional tool in the treatment of a difficult and often chronic condition. Many of you work clinically with consumers who are dependent on opioids, such as heroin or any of the popular pain relievers on the market. Heroin is a drug that is usually injected, sniffed/snorted, or smoked. Typically, a heroin abuser may inject up to four times a day. Intravenous injection provides the greatest intensity and most rapid onset of euphoria (7 to 8 seconds), while intramuscular injection produces a relatively slow onset of euphoria (5 to 8 minutes). When heroin is sniffed or smoked, peak effects are usually felt within 10 to 15 minutes. One of the most detrimental long-term effects of heroin is addiction itself. Addiction is a chronic, relapsing disease,

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Cicatelli Associates Inc.
Five Borough AIDS Mental Health Project
HIV/AIDS Training and
Technical Assistance Project

Barbara Cicatelli
Project Administrator

Theresa Keane, Ph.D.
Managing Editor

Keran Deli
Director of Curriculum and Publications

Tim Hunt, CSW, CASAC
Editor, Deputy Director
Behavioral Health Division

Luis R. Torres, M.A.
Director of Behavioral Health Division

Under contract with the
New York City Department of
Health and Mental Hygiene
Thomas R. Frieden, M.D., MPH
Commissioner

Division of Mental Hygiene
Lloyd Sederer, M.D.
Executive Deputy Commissioner

Bureau of Strategic Planning
Jane Plapinger, MPH

Office of Contract Management
Victoria Pope

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this quarterly represent solely
the opinion of the authors.

Cicatelli Associates Inc.
505 Eight Avenue, Suite 1601
New York, NY 10018
P: (212) 594.7741
F: (212) 629.3321
E: tim@cicatelli.org

www.cicatelli.org

From the Desk of Lloyd I. Sederer, M.D., Executive Deputy Commissioner, and Andrew Kolodny, M.D., Medical Director for Special Projects, Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene

One fifth of all heroin users in the U.S. live in New York City. We have the highest number of heroin users and the highest rate of heroin use per capita in the country. Though heroin addiction can be effectively treated with medications, the appeal and effectiveness of pharmacotherapy has been limited by onerous state and federal regulations. Many heroin users will not visit a clinic every day for a daily dose of methadone. There are about 200,000 heroin users in New York City but only 38,000 are enrolled in methadone treatment programs.

Without treatment, many heroin users are at high risk of developing HIV and hepatitis. Intravenous drug use still accounts for approximately one-third of new HIV infections in the United States (Stancliff, 2004). A recent literature review of HIV and substance abuse treatment reports that current or recovering users of both injected and non-injected substances make up the largest portion of PWHA (HDWG, 2002). In addition to an increased risk of contracting infectious diseases, untreated heroin addiction may result in death from overdose, unemployment, family disruption and violence.

A new pharmacological treatment is now available that holds promise for many that have not availed themselves of needed services. In Oct. 2002, the U.S. Food and Drug Administration approved buprenorphine as a controlled Schedule III drug for the treatment of opioid

dependence. Buprenorphine, a derivative of opium, has been marketed in the USA for many years as a treatment for pain. The brand name for the buprenorphine monotablet is Subutex®. The combination buprenorphine–naloxone tablet is Suboxone®. The combination product contains the opioid antagonist naloxone and is designed to decrease the potential for abuse by producing withdrawal symptoms if used parenterally. Buprenorphine has minimal oral bioavailability. The route of delivery is sublingual.

Like methadone, buprenorphine reduces craving and permits productive living. Although methadone may work better for some individuals, buprenorphine has some significant advantages. These advantages include:

- Prescribed in a doctor's office and filled at a pharmacy
- Safer because of a "ceiling" effect on respiratory depression (however overdose is still possible if patients combine buprenorphine with other central nervous system depressants, such as benzodiazepines or alcohol)
- Less likelihood of abuse and diversion
- Longer duration of action
- Clearer thinking
- Milder withdrawal symptoms

We anticipate that people using heroin who have been discouraged from using methadone will see buprenorphine as a better alternative. We are working to see that over the next 5 years there



are tens of thousands of individuals receiving buprenorphine treatment. Our efforts to achieve this goal include promoting the use of buprenorphine treatment in primary care, AIDS clinics, methadone clinics, and in the New York City correctional system and advocating for fair reimbursement and less burdensome regulations. In addition, we are attempting to inform health care providers, community leaders, clergy and families about buprenorphine treatment so that they will work with us to see that heroin users are encouraged to seek out treatment. We are able to track the number of physicians prescribing and the number of patients taking buprenorphine so we will know if our efforts are succeeding.

Physicians that take a training class and apply for a waiver from the Drug Enforcement Agency are permitted to prescribe buprenorphine for opioid dependence. To find these physicians, SAMHSA (The Substance Abuse & Mental Health Services Administration), a federal government agency, maintains The Buprenorphine Physician Locator. The Locator enables you to search by city, state and ZIP code to find a qualified physician. Search results include a list of physicians and maps to the treatment locations. Contact information is also included, as are facility addresses and telephone numbers. The locator can be accessed from SAMHSA's buprenorphine website:

<http://buprenorphine.samhsa.gov/>
Information about buprenorphine can
also be obtained by visiting the website:
<http://www.suboxone.com/>

We recognize that many heroin users will require more than just buprenorphine to remain sober. People who are addicted to drugs often have other problems that make it difficult for them to quit. Mood, anxiety, and personality disorders as well as social and occupational problems are

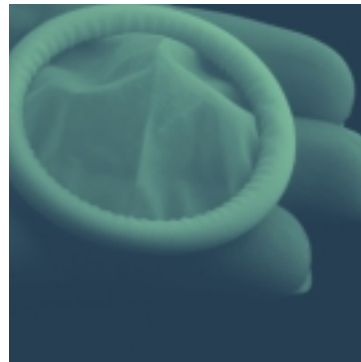
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TEACHING HARM REDUCTION STRATEGIES TO PERSONS WITH MILD TO MODERATE RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES

Submitted by: Pat Sutherland-Cohen, M.A. and Bobra Fyne, CSW

A major goal of HIV/AIDS education programs has been to help people move successfully from higher risk behaviors to lower risk behaviors. For example, for sexually active individuals, that may mean moving from sex without a condom to using a condom every time one has sex. For others, it may mean moving from sexual intercourse to non-penetrative sex. For others still, it may involve choosing sexual abstinence over sexual activity.

Whether decreasing their substance use or engaging in safer sex behaviors, people with MR/DD are adjusting their behaviors during the HIV/AIDS pandemic. As a result, trainers/educators have learned that behavior change happens along a continuum in a non-linear fashion and that successful changes are gradual. It is important to bear in mind that rapid and drastic changes are often expected from our clients, including those with cognitive limitations or mental health challenges. Like other professionals working with challenging populations, counselors and trainers working with MR/DD populations need to reconsider



their expectations for behavior change. It is important however, that clients comprehend the ramifications of each possible option in order to make the best possible choice. For persons who choose to be sexually active as opposed to practicing abstinence, an effective barrier method such as condom is an important harm reduction tool.

When the standards we hold for our clients are unrealistically high, we run the risk of closing the door to communication. In our experience, persons with MR/DD often try to please the people with whom they work, and this may serve as a barrier to communication as well.

For many years, workers in the field of addiction have followed a model of harm reduction developed by Prochaska and DiClemente (1992). This model is now broadly applied to other life areas that people want to change, including sexual behaviors. While their original research identified four stages of change, further research identified six. These stages include Precontemplation, Contemplation, Preparation or Determination, Action and Maintenance.

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NEWS YOU CAN USE

PREVALENCE OF ALCOHOL AND OTHER DRUG USE IN THE USA

SAMHSA (2003) estimated that 22 million Americans aged 12 or older in 2002 are classified with substance dependence or abuse. That figure constitutes 9.4 percent of the total U.S. population. Of this number 3.9% are dependent on drugs other than alcohol. SAMSHA (2003) also estimates that 338,000 Americans who are age 12 or older have injected heroin, cocaine, stimulants, or other drugs.

U.S. Department of Health and Human Services (2003). National Household Survey on Drug Abuse: Injection drug use. *Substance Abuse and Mental Health Services Administration: Rockville, Md.* <http://www.oas.samhsa.gov/2k3/ivdrug/ivdrug.pdf>

(continued on next sidebar)

From the Desk of Lloyd I. Sederer, M.D.

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often impediments to recovery. Psychiatric treatment and psychosocial approaches that address these needs are thus often a critical part of effective treatment. These approaches include psychiatric care, counseling, family and couples therapy, and 12-step programs such as Narcotics Anonymous. Referral resources can be obtained by calling:

1-800 LIFENET/800-543-3638, or 311 for substance abuse information and referral.

By engaging thousands of heroin users in treatment with buprenorphine we have an opportunity to save lives and improve costly social problems including the destruction of families, the spread of diseases, and an overburdened criminal justice system.

Health and Disability Working Group (2002).

Boston University School of Public Health, Performance Standards, Barriers to Care and Innovative Program Models for HIV-Positive Substance Users: A Review of the Literature <http://www.bu.edu/hdwg/reports/SALitreview.pdf>

BELOW, WE PRESENT MORE DETAIL REGARDING THE PSYCHOPHARMACOLOGICAL ASPECTS OF BUPRENORPHINE.

DRUG INTERACTIONS

Buprenorphine is metabolized in the liver by the cytochrome P450 3A4 system. The use of medications or foods that inhibit 3A4 (e.g., azole antifungal agents, macrolide antibiotics, protease inhibitors, nucleoside reverse transcriptase inhibitors) may lead to increased plasma levels of buprenorphine. Exposure to substances that induce the 3A4 system, such as phenobarbital, may have the opposite effect. Severe or fatal respiratory depression generally only arises with the concomitant use of a central nervous system depressant other than heroin or methadone (particularly a benzodiazepine or alcohol in excessive amounts), or if buprenorphine is used intravenously. [ref: (Subutex®, Suboxone®, [package insert]. Hull, UK:Reckitt Benckiser Healthcare (UK) Ltd.]

SPECIAL POPULATIONS

<i>Pregnancy</i> ^{1,2}	Buprenorphine is a Pregnancy Category C drug (Risk Cannot Be Ruled Out) Naloxone is a Pregnancy Category B drug (No Evidence of Risk In Humans). The manufacturer advises against use in pregnancy
<i>Lactation</i>	The poor oral bioavailability of buprenorphine suggests that use by lactating women may be safe; however, data are lacking. Safety of naloxone in lactating women is not known.
<i>HIV/AIDS2002</i>	Because it is metabolized by the cytochrome P450 system, buprenorphine should be used with caution in patients concurrently treated with protease inhibitors or nucleoside reverse transcriptase inhibitors. Nonetheless, there may be significantly fewer drug interactions between buprenorphine and anti-retroviral medications than occur with methadone. [Gourevitch, Carrier]
<i>Liver impairment</i> (hepatic)	Use with caution in patients with hepatic impairment as buprenorphine is primarily metabolized in the liver.
<i>Kidney impairment</i>	No data indicate adverse effects in this population.
<i>Geriatric patients</i>	Lower doses may be indicated in elderly patients; however, experience in this population is very limited.
<i>Pain</i>	Sublingual buprenorphine is not FDA-approved for the treatment of pain. Whenever possible, pain should be treated with non-opioid medications in patients taking buprenorphine. Administering buprenorphine after a patient has been given an opioid medication for pain could precipitate withdrawal.

¹ Data on the safety and efficacy of buprenorphine in pregnant women are limited; case reports and small clinical series have indicated safe and effective use (Fisher, 1998).

² Physicians must carefully weigh risks and benefits of this drug compared to continued opioid use or to referral for methadone treatment (the treatment of choice in pregnancy).

TEACHING HARM REDUCTION STRATEGIES TO PERSONS WITH MILD TO MODERATE RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES

Stancliff, S. (2004). Buprenorphine and the Treatment of Opioid Addiction. *The PRN Notebook On-Line Edition Summary* by Tim Horn. Edited by Richard E. Gold, DO, Steven S. Kipnis, MD, FACP, FASAM
http://www.prn.org/prn_nb_cntnt/vol9/num1/stancliff_frm.htm.

Readers who are interested in becoming certified to prescribe Buprenorphine should refer to the News You Can Use Section of this newsletter where resource and training information is provided. For general information regarding matters related to mental health care in New York City or to locate a physician certified to prescribe buprenorphine treatment, please refer to below-referenced resources.

BUPRENORPHINE PHYSICIAN LOCATOR
1-866-BUP-CSAT/ 866-287-2728
<http://buprenorphine.samhsa.gov>

LIFENET TELEPHONE NUMBERS AND WEBSITE
24 Hours a Day and Seven Days a Week

- In English:
1-800-LIFENET (1-800-543-3638)
- In Spanish:
1-800-AYUDESE (1-877-298-3373)
- In Chinese:
1-800-ASIAN LIFENET (1-877-990-8585)

For other languages, call 1-800-LIFENET and ask for an interpreter.

TTY hard of hearing, call (212) 982-5284

What follows is a brief description of each phase:

- **Precontemplation:** the stage in which the person is not yet considering the possibility of change and may not view the behavior as a problem.
- **Contemplation:** this stage is often characterized by ambivalence. The person simultaneously considers change and rejects it.
- **Preparation-Determination:** in this stage, the person's statements reflect a good deal of what might be judged to be "motivation". Ambivalence is not necessarily resolved, and their decision-making process continues.
- **Action:** in this stage, the person engages in focused activities intended to bring about a change and often seeks a health care professional for support.
- **Maintenance:** when the person attempts to sustain the change accomplished by the previous Action stage and struggles to prevent a relapse.

In the process of change people often return to previous behaviors. These slips can lead to full-scale relapse if not addressed. **Relapse** represents a full-scale return to previous behavior, with no pretense of continuing the change. Relapse is considered in this model, more common than not, and, therefore, is a natural part of the change process.

Prochaska and DiClemente's stages of change offer counselors a valuable model for understanding and teaching about HIV/AIDS risk reduction. In the past, we have assumed that if provided with complete information, clients should be ready to change behaviors. Use of this model enables us to help the consumer

move toward making safer choices by tailoring our interventions and services to their stage readiness for change. If a client is in the Action stage, for example, they may be ready to buy a favorite type of condom, practice using a dental dam or use any verbal tools at their disposal to facilitate a behavior change. If, however, their partner is in the precontemplation stage, there may be little chance of negotiating safer sex. In this scenario, counselors can support each partner's exploration of alternatives along the continuum of safer sex behaviors.

If both persons are in the precontemplation or contemplation stage, neither person may have the resolve to practice safer sex. Partners in the action or maintenance stages have the greatest likelihood for consistent successful use of safer sex strategies. Furthermore, it is important to keep the focus on behaviors that are safer. If a client has trouble putting on a condom

due to problems with dexterity, use of a contraceptive suppository is better than no protection at all. Clients may be limited only by their counselor's creativity. That is, our clients may be more willing to experiment with new behaviors and different choices as we increase the range of our teaching/counseling repertoire. Prochaska and DiClemente's model of behavior change allows individuals to assess their readiness for change, to develop the skills they need for successful change and to feel empowered in the process.

For more information about HIV prevention services for people with developmental disabilities or other at YAI/National Institute for People with Disabilities services, please contact Bobra Fyne at (212) 273-6202.

REFERENCES

Prochaska, J., & DiClemente, C. (1992). *American Psychologist*, 47, 1102-1114.

our clients may be more willing to experiment with new behaviors and different choices as we increase the range of our teaching/counseling repertoire

NEWS YOU CAN USE

INJECTION DRUG USE – WHAT IS IT?

“Injection Drug User” or IDU refers to any type of drug use in which injection equipment is used to administer the drug. Drugs that are commonly injected include heroin, cocaine, steroids, and various combinations of “street drugs”. Infection through direct or indirect IDU still represents a large proportion of the new diagnoses of AIDS. In the year 2000, 28% of new cases of AIDS were attributed to IDU. In the year 2002, 24% of new cases of AIDS were attributed to injection drug use (HRSA, 2004; CDC, 2001). Fourteen percent (14%) of current IDUs believe that needles they had used to inject drugs had been used by others. (SAMHSA, 2003)

Health Resources and Services

Administration (2004). Buprenorphine: A new tool in the arsenal. *HRSA Care Action: Providing HIV/AIDS care in a changing environment*. Retrieved on April 19, 2004 from <http://hab.hrsa.gov/publications/march04/#a1>

U.S. Department of Health and Human

Services (2003). National Household Survey on Drug Abuse: Injection drug use. *Substance Abuse and Mental Health Services Administration: Rockville, Md.* <http://www.oas.samhsa.gov/2k3/ivdrug/ivdrug.pdf>

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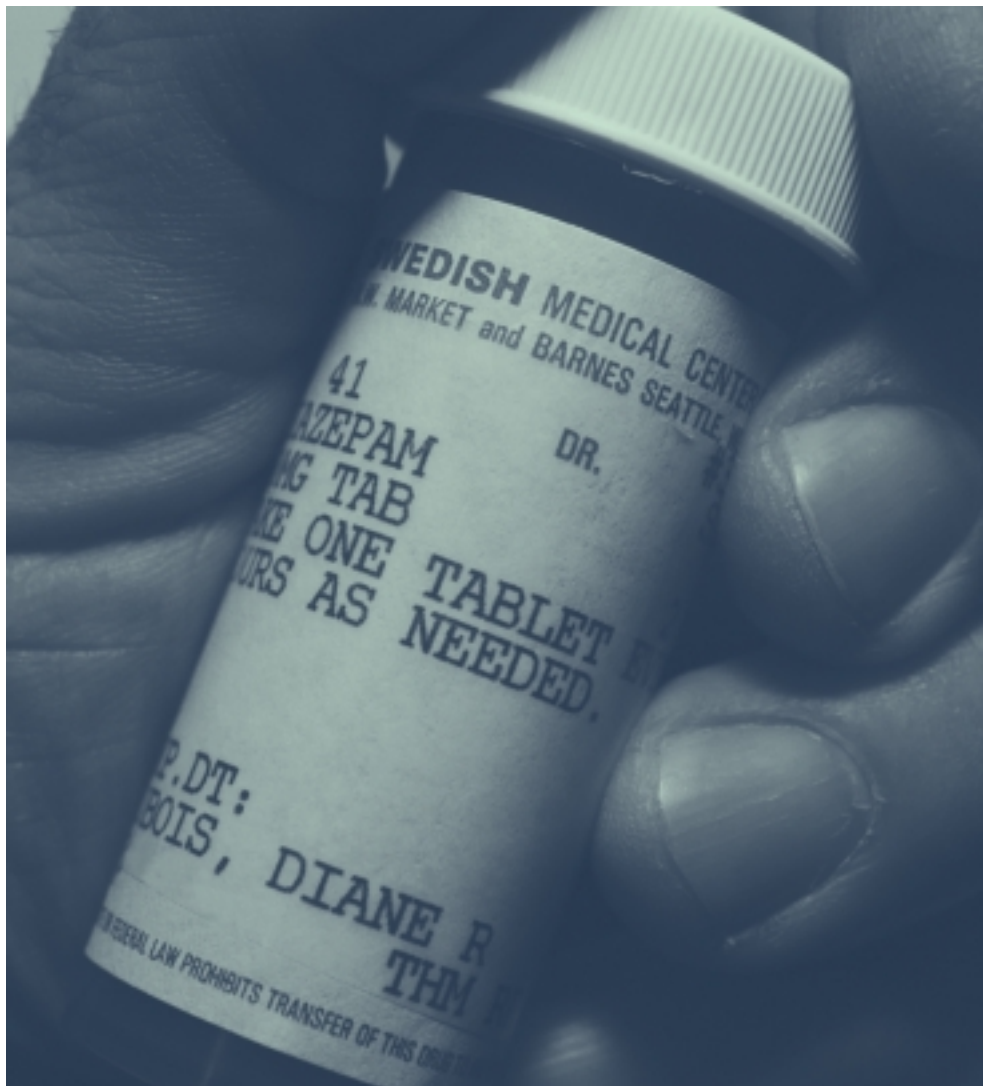
The Use of Buprenorphine for Opiate Dependence

(continued from page 1)

There is ample evidence of an alarming rise in the misuse of prescription drugs. An estimated 9 million Americans currently use prescription drugs for non-medical reasons (NIDA, 2004). Many individuals use prescribed opiates for legitimate medical conditions that involve physical pain. This is especially true of individuals with HIV, who suffer from pain related to neuropathy and other HIV-related processes. Some of these individuals find, to their surprise, that they have become physically dependent on the medicine. Similarly, a person might experiment with heroin, and within a brief period of time discover that they need to keep using the drug to prevent symptoms of withdrawal. Rates of heroin use continue to rise, largely attributable to widespread availability of very high-grade heroin. It is estimated that there are approximately 160,000 persons who use heroin in New York City (Frank, 2000).

Until recently, people with an opioid dependence had very few treatment choices. The federal government's limitations on opiates started about a century ago, with the Pure Food and Drug Act of 1906 and then the Harrison Narcotic Act of 1914. Methadone was the only drug available to treat opiate dependence for decades. Methadone acts by binding to opiate receptors in the brain, thereby blocking effect of other opiates that might be used. It comes in the form of a wafer, a pill, or as a pink liquid. Methadone is used to detoxify people from opioid dependency in detoxification units. In that case, methadone is used over a short period of time. Another use of methadone also is in the form of methadone maintenance therapy. Methadone maintenance is almost always dispensed in the context of an outpatient clinic which has a staff consisting of physicians, nurses, and counselors. It is often taken for protracted periods of time (months to years). Buprenorphine seems to have several treatment advantages over methadone. For one, it

is difficult to overdose on buprenorphine. Second, it is hard to use in increasingly high doses because the drug has a ceiling effect. Taking too much buprenorphine triggers antagonizing effects, leading the cell's opiate-receptor system to shut down. This can induce withdrawal. Buprenorphine is also preferable to methadone for opiate maintenance and outpatient detoxification for some because it can be administered and prescribed in a physician's office, rather than in a methadone clinic. This setting may be more convenient and less restrictive than a methadone maintenance setting. In general, the administrative burdens associated with buprenorphine are far less. According to Dr. Herbert D. Kleber, professor of psychiatry and director of the New York State Psychiatric Institute's Division on Substance Abuse, “buprenorphine is suitable for people who, even though they have a substance abuse problem, are employed and have continued family ties, for example. Methadone is more suitable for people who need a more structured environment and more supervision.” Aside from the logistical barriers that methadone clinics pose for working people, they also carry a stigma that they are only for “hardcore” heroin addicts. This stigma deters working people. Thus, while methadone maintenance settings may work well for those who require a higher level of care in the form of structure and supervision, other consumers might experience methadone clinics as overly rigid with respect to their restrictions and regulations. The federal government is limiting the number of buprenorphine consumers within a physician's practice to 30. This limit is quite controversial. In some areas, there are few physicians but many opiate dependent consumers. Another control mechanism in place is that physicians can prescribe either of two pill forms of the drug – buprenorphine alone or buprenorphine combined with naloxone, a counteractive drug that blocks buprenorphine in some conditions. Naloxone does not interfere with buprenorphine when the pills are taken according to protocol. If the combination is sold in the street however, and then ground up and injected, the naloxone will block buprenorphine's



action and the person will go into immediate withdrawal. This is extremely painful but rarely life-threatening. For best results, patients should begin taking Buprenorphine when they are in the early stages of withdrawal. Induction programs are thought to be the best way to resolve the few logistical issues involving buprenorphine. Programs will also work best if a multi-disciplinary team approach is utilized.

The Buprenorphine Program of Columbia University has as its mission the education of consumers and clinicians about buprenorphine,

and is setting up protocols to ensure that physicians and consumers use buprenorphine in the most effective way. The initiative is housed in the Department of Psychiatry's Substance Abuse Division. After the consumer has been started on the drug, the Columbia program refers the person to physicians certified to prescribe Buprenorphine or retains the consumer at Columbia for maintenance and possible detoxification. The Columbia program has transferred over a hundred patients onto buprenorphine to date and we feel that the medication is proving to be clinically effective.

The Buprenorphine Program is planning research on the most effective induction protocols and seeks to explore the best and safest methods to maintain and detoxify patients.

In summary, buprenorphine has many advantages over more traditional treatments available for opiate dependence. It is difficult to overdose on it, it has a ceiling effect which decreases the likelihood of abuse, and it can be used in flexible settings. It also seems to have an "awakening effect" and a positive effect on mood stabilization. Furthermore it is legal, and can be obtained in the privacy of a physician's office. The Buprenorphine Program at Columbia University is a program that is on the forefront of bringing this promising treatment to the many people who can benefit from it.

The Buprenorphine Program at Columbia

University includes Herbert D. Kleber, M.D., a nationally recognized expert in substance abuse, and former deputy drug czar in the administration of George Bush Sr. Other members of the Buprenorphine Program include Erik Gunderson MD, Margaret Rambone, Ph.D., and Roberta Sales, RN, MPH.

More information may be obtained at:
(212) 342-1496 OR info@bupprogram.com OR
www.BupProgram.com

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Frank, B. (2000). An overview of heroin trends in New York City, past, present and future. *Mount Sinai Journal of Medicine.* 67, 5/6, 304-346.

National Institutes for Drug Abuse (2004).

Prescription Drugs: Abuse and Addiction. *NIDA Research Report Series.* May 9, 2004.
<http://www.nida.nih.gov/ResearchReports/Prescription/Prescription.html>

NEWS YOU CAN USE

INTEGRATED MEDICAL AND SUBSTANCE USE TREATMENT SERVICES

Boston University School of Public Health's Health and Disability Working Group (HDWG, 2003) and James Bell Associates, Inc. (JBA) have recently reviewed the literature on the integration of HIV medical services with mental health and substance abuse treatment (Soto et al. 2004). These investigators have outlined several different approaches to integration of services:

- "One stop shopping." These programs offer medical, substance abuse treatment, mental health, and/or other supportive services in the same location
- Forming partnerships with other services: Agencies work closely together in the care of shared clients. There is regular, ongoing and frequent communication between agency staff treating the same patients. Providers from allied services participate in regular case conferences, treatment planning, etc.
- Intensive care coordination: This strategy utilizes an Intensive HIV Case Management approach in which the team includes social workers, nurses, case managers, peer navigators, patient advocates, or some combination thereof.

The reviewers also delineated the components of successful integrated service programs. In addition to offering some form of integrated services, successful programs also employ the following approaches:

- Multidisciplinary team approach to care: Delivery of care through teams composed of clinicians and other providers, including nurses, mental health professionals, and case managers, were found to be effective. Teams might also include paraprofessionals and peers. All effective programs instituted measures to ensure effective communication between disciplines through case conferencing and other venues. (HDWG, 2003)
- Lower threshold of care: Focusing on the barriers that "triple diagnosis" patients face in accessing and staying in care, successful programs institute procedures to minimize these factors, such as flexible appointment times or providing transportation .
- Conducting outreach and follow-up: Programs recruit new patients and/or get back in touch with those that have missed appointments through the use of peer outreach workers.
- Treatment adherence support: Programs may offer a variety of interventions to assist clients in HIV medication adherence. Support and educational groups, home visits by nursing or other staff, educational materials, and pharmacy assistance and counseling, have been employed.
- Culturally competent service delivery: Programs are particularly sensitive to racial and ethnic issues as important variables in care provision. They also utilize interventions tailored to special

populations affiliated by illness, gender, sexual orientation, type of drug used, age, and employment status.

Health and Disability Working Group

(2003). Guiding Principles for Programs Serving HIV Positive Substance Users. *Boston University School of Public Health*. Retrieved on April 19, 2004 from <http://www.bu.edu/hdwg/projects/rainingfiles/GuidingPrinciples.pdf>

Soto, T., Bell, J., & Pillan, M. (2004).

Literature on integrated HIV care. *Unpublished manuscript*.

BUPRENORPHINE AND HIV MEDICATIONS

Researchers have demonstrated that buprenorphine can be administered in conjunction with HIV medications while carefully monitoring dosage of both categories of medicines. Carrieri and colleagues (2000) showed that buprenorphine did not impact the efficacy of HAART. Iribarne et al. studied the effects of three protease inhibitors (Ritonavir, Indinavir, and Saquinavir) administered with methadone or buprenorphine. They showed that "coadministration of some protease inhibitors with opiate substitutes would result in significantly higher amounts of opiate substitute." They concluded that:

- Ritonavir should be used carefully in case of co-administration of methadone or buprenorphine, due to the possible risk of opiate substitute overdose.
- Indinavir would be expected not to alter methadone metabolism but may strongly inhibit the action of buprenorphine.
- Saquinavir would not alter methadone or buprenorphine metabolisms.

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**DEVELOPING LOCAL SYSTEMS
OF CARE FOR CHILDREN AND
ADOLESCENTS WITH EMOTIONAL
DISTURBANCES AND THEIR
FAMILIES: EARLY INTERVENTION**

06/23/2004-06/27/2004

Sponsor: Georgetown University Center for
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Contact: National Technical Assistance Center
for Children's Mental Health
Georgetown University Center for Child and
Human Development
3307 M Street, NW, Suite 401
Washington, DC 20007
Phone: (202) 687-5000
Fax: (202) 687-1954
Email: institutes2004@mindspring.com

Website: [http://gucchd.georgetown.edu/
institutes.html](http://gucchd.georgetown.edu/institutes.html)

Georgetown University is offering Training
Institutes on local systems of care for children
and adolescents with or at risk for emotional
disturbances and their families. The intent of
the Institutes is to provide in-depth, practical
information on how to develop and sustain sys-
tems of care and how to provide high quality,
effective clinical interventions within them.

**COMPLEXITIES OF CO-OCCURRING
CONDITIONS: HARNESSING
SERVICES RESEARCH TO IMPROVE
CARE FOR MENTAL, SUBSTANCE USE,
& MEDICAL/PHYSICAL DISORDERS**

06/23/2004-06/26/2004

Marriott Wardman Park Hotel
Washington, DC

Contact: Tanya Davis, Conference Registrar:
240.744.7000, ext. 7012

Website: <http://www.cccconference.com/>

The conference will explore research and prac-
tices regarding the organization, management,
and financing of prevention, treatment, and
aftercare services for individuals at risk for or
suffering from co-occurring mental illness,
problem alcohol and drug use, and other med-
ical or physical conditions.

UPCOMING EVENTS

**"WOMEN ACROSS THE LIFE SPAN:
A NATIONAL CONFERENCE ON
WOMEN, ADDICTION AND
RECOVERY"**

07/12/2004-07/13/2004

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110 South Eutaw Street
Baltimore, Maryland 21201
(410) 962-0202

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Services Administration (SAMHSA), Center for
Substance Abuse Treatment (CSAT):

Contact: Ayanna Dixon (301) 495 - 3787, ext.
3130 or e-mail at ADixon@jbs1.com

For more info: SAMHSA
[http://conferences.jbs.biz/women_and_
childwelfare/](http://conferences.jbs.biz/women_and_childwelfare/)

The conference will examine the provision of
gender-specific treatment to women through-
out their lives. Topic areas for the plenary ses-
sions and workshops, as they pertain to
women, include:

Co-occurring Mental Health Disorders
Treatment Capacity
Prevention and Early Intervention
Addressing Needs of Children and Families
Homelessness
Infectious Diseases
Criminal Justice
Trauma and Violence

**AMERICAN PSYCHOLOGICAL
ASSOCIATION ANNUAL
CONVENTION 2004**

07/28/2004-08/01/2004

Hawaii Convention Center
Honolulu, Hawaii

Contact: e-mail: convention@apa.org
or 202-336-6020

Website: <http://www.apa.org/convention/>

Topics will include:

Men Are From Mars, Women Are From You Know
Where: A Debate About the Nature of Gender
Differences

Asian Alternatives to American Psychology
Business-Psychology Partnerships: Working
Together for Working Families

**CASA CONFERENCE: SO HELP ME GOD:
SUBSTANCE ABUSE, RELIGION AND
SPIRITUALITY**

09/22/2004

New York City

Sponsor: National Center for Addiction and
Substance Abuse at Columbia University
CASA, 633 Third Ave., 19th Floor, New York City
Contact: William P. Coyle at 212-841-5277

Website: <http://www.casacolumbia.org/>.

The conference will explore the roles that
spirituality and religion play in prevention of and
in recovery from substance abuse.

NEWS YOU CAN USE

Taken together, these results indicate that caution should be used in the clinical use of methadone and buprenorphine when protease inhibitors are co-administered (Iribarne et al. 1998).

Carrieri M.P., Vlahov D. et al. (2000). Use of buprenorphine in HIV-infected injection drug users: Negligible impact on virologic response to HAART. *The Manif-2000 Study Group. Drug and Alcohol Dependence*, 60(1), 51-54.

Iribarne, C. et al. (1998). Inhibition of methadone and buprenorphine N-dealkylations by three HIV-1 protease inhibitors. *Drug Metabolism Disposition*, 26(3), 257-260.

EFFICACY OF BUPRENORPHINE IN "GENERAL" PRIMARY CARE

Studies of buprenorphine treatment in primary care have confirmed the efficacy of integrating that option into other treatment settings. O'Connor et al. (1998) reported on the treatment of heroin addicts in primary care settings as compared to those treated in methadone maintenance settings. They found that "retention during the 12-week study was higher in the primary care setting (78%) than in the drug treatment setting (52%). Patients admitted to primary care had lower rates of opioid use based on results of urine toxicology (63% versus 85%) and were more likely to achieve 3 or more consecutive weeks of abstinence (43% versus 13%).

O'Connor, P.G., Oliveto, A.H., Shi, J.M., 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(2), 100-105.

PHYSICIANS CAN OBTAIN INFORMATION ON THE REQUIRED TRAINING FROM THE FOLLOWING ORGANIZATIONS:

American Academy of Addiction Psychiatry

7301 Mission Rd, Suite 252
Prairie Village, KS 66208
913-262-6161
Fax: 913-262-4311
E-mail: info@aaap.org
<http://www.aaap.org>

American Osteopathic Academy of Addiction Medicine

5550 Friendship Blvd, Suite 300
Chevy Chase, MD 20815
301-968-4160
Fax: 301-968-4199
E-mail: aoaam@osteohdq.org
<http://www.aoa-net.org/affiliatedorgs/specialty.htm>

American Psychiatric Association

1400 K St NW
Washington, DC 20005
888-357-7924
Fax: 202-682-6850
E-mail: apa@psych.org
<http://www.psych.org>

American Society of Addiction Medicine

4601 N Park Ave, Arcade Suite 101
Chevy Chase, MD 20815
301-656-3920
Fax: 301-656-3815
E-mail: email@asam.org
<http://www.asam.org>

Center for Substance Abuse Treatment

5600 Fishers Ln
Rockwall 11, Suite 615
Rockville, MD 20857
301-443-5700
Fax: 301-443-8751
E-mail: info@samhsa.gov
<http://www.samhsa.gov/centers/csat/csat.html>

Training for Allied Health Care Professionals

It is important that non-medical health care providers, nurses, mental health care providers, counselors, social workers and case managers also gain knowledge about the use of buprenorphine in HIV primary care settings. On-line training can be accessed through Danya Institute's Central East Addiction Technology Transfer Center at <http://www.danyalearningcenter.org/>.

For further information:
<http://buprenorphine.samhsa.gov/>
http://buprenorphine.samhsa.gov/bwns_locator/index.html.

SAMHSA site also operates a Spanish Language information line at 1-866-287-2728.

A Letter from the Editor

(continued from page 1)

characterized by compulsive drug seeking and use, and by neurochemical and molecular changes in the brain.

Two of the hallmark signs of opioid dependency are the development of tolerance and symptoms of withdrawal when the drug is removed. Tolerance refers to the fact that more of the drug is needed over time to achieve the desired "high". Withdrawal comes with physical dependence, when the body adapts to the presence of the drug and withdrawal symptoms occur if use is reduced abruptly. Withdrawal may occur within a few hours after the last time the drug is taken. Symptoms of withdrawal include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps ("cold turkey"), and leg movements. Major withdrawal symptoms peak between 24 and 48 hours after the last dose of heroin and subside after about a week. However, some people have shown persistent withdrawal signs for many months. As with abusers of any addictive drug, heroin abusers gradually spend more and more time and energy obtaining and using the drug. Once they are addicted, the heroin abuser's primary purpose in life becomes seeking and using drugs.

We are covering this important topic because opioid dependency remains a serious problem in many communities in New York City. There are approximately 160,000 heroin users in New York City (Frank, 2000). It is a difficult addiction to treat and historically there have not been many treatment alternatives available.

Possible treatment options include detoxification, methadone maintenance and other medications including LAAM, nalaxone and naltrexone. As our writers inform us in this edition, buprenorphine is a drug that partially blocks opioid receptors in the brain. It appears that buprenorphine carries a low risk of abuse, addiction and side effects. Moreover, it may have fewer interactions with anti-viral drugs that are used in the treatment of HIV/AIDS. A unique feature of buprenorphine is that it can be prescribed in settings other than drug treatment settings, which increases its accessibility.

The Five Borough AIDS Mental Health Alliance (FAMHA) is a program funded by the Department of Health and Mental Hygiene that seeks to disseminate cutting edge information to providers working with people with HIV/AIDS who are also struggling with a mental health diagnosis. The issue includes articles that provide an overview of the scope of opioid dependency, of buprenorphine treatment and describe developing initiatives in New York City. We hope you find the articles useful! Please let us know what you think by emailing tim@cicatelli.org.



REFERENCES

Frank, B. (2000). An overview of heroin trends in New York City: Past, present and future. *Mount Sinai Journal of Medicine*. 67(5/6): 304-346.

FOR MORE INFORMATION

Health and Disability Working Group, Boston University School of Public Health, Guiding Principles for Programs Serving HIV Positive Substance Users. <http://www.bu.edu/hdwg/projects/trainingfiles/GuidingPrinciples.pdf>

Health and Disability Working Group, Boston University School of Public Health, Performance Standards, Barriers to Care and Innovative Program Models for HIV-Positive Substance Users: A Review of the Literature <http://www.bu.edu/hdwg/reports/SAlitreview.pdf>

Health and Disability Working Group, Boston University School of Public Health, Successful Strategies in Serving HIV-Infected Substance Users: A Case Study Report <http://www.bu.edu/hdwg/projects/trainingfiles/overview.pdf>

Howell, K. MD Treatment of Nicotine and Opioid Dependence, delivered at The State of the Art in Addiction Medicine. October 30, 2003 - November 1, 2003, Washington, DC

HRSA, Buprenorphine: A New Tool in the Arsenal. HRSA CARE ACTION on the web at <http://hab.hrsa.gov/publications/march04/#a1>

HRSA, Substance Abuse and HIV http://hab.hrsa.gov/reports/report_05_03.htm#assess

Stancliff, Sharon. Buprenorphine and the Treatment of Opioid Addiction. The PRN Notebook On-Line Edition Summary by Tim Horn. Edited by Richard E. Gold, DO, Steven S. Kipnis, MD, FACP, FASAM http://www.prn.org/prn_nb_cntnt/vol9/num1/stancliff_fm.htm

A brief screening instrument which is widely used in the field when assessing for alcohol and other drug use.

CAGE-AID

Clinicians may ask the following questions with patients responding yes or no:

- C** In the last three months, have you felt you should Cut down or stop using drugs?
- A** In the last three months, has anyone Annoyed you by criticizing your drug use?
- G** In the last three months have you felt Guilty about your drug use?
- E** In the last three months, have you ever wanted to use drugs (Eye-opener) first thing in the morning?

Each yes answer indicates a possible problem. Two or more indicate a problem is likely.

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THE FIVE BOROUGH AIDS MENTAL HEALTH ALLIANCE (FAMHA) is an educational project managed by Cikatelli Associates Inc. (CAI) and funded by the New York City Department of Health and Mental Hygiene. The project's mission is to provide training and technical assistance on subjects related to HIV/AIDS mental health including such topics as assessment and treatment of co-occurring mental health and substance use problems. A wide array of training and technical assistance programs are available for agencies providing services to people living with HIV/AIDS. Readers may request programs by completing the application for training form on the back cover of the newsletter and returning it to CAI. **For further information, please contact behavioralhealth@cicatelli.org.**



5 FAMHA Service Needs Assessment

To request a FAMHA program for your agency/organization, complete the following needs assessment and submit it by mail or fax to:

Cicatelli Associates Inc. • 505 Eighth Avenue, Suite 1601 • New York, NY 10018
phone: (212) 594-7741 • fax: (212) 629-3321 • e-mail: tim@cicatelli.org

Name _____

Agency/Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ E-mail _____

Desired Training Day(s)/Time(s) _____ Anticipated Audience Size _____

Attending Disciplines

(check all that apply)

- Clergy
- Counseling
- Marriage/Family Therapy
- Medicine
- Nursing
- Psychiatry
- Psychology
- Social Work
- Case Management
- Other (please identify):

Desired Training Format

(check all that apply)

- Grand Rounds
- Interactive Small Group
- Lecture

Desired Training Topic

(check all that apply)

- Treatment Update/Adherence Issues
- Harm Reduction Strategies
- Management for Active Substance Abusers

- Case Management for HIV-Infected Clients
- Issues Relevant to Culturally Competent Service Delivery
- Family-Focused Mental Health Services
- HIV Pre/Post-Test Counseling
- Building HIV Support Groups
- Stress Management
- Boundaries and Countertransference
- Suicide Assessment and Prevention

Technical Assistance:

Face-to-Face Skill Building/ Consultation with Agencies

(check all that apply)

- Making Referrals
- Cultural Diversity
- Behavior Change Models
- Human Resource Development
- Infrastructure Building
- Managed Care
- Implementation of Risk Reduction Groups in MICA Programming

- Special Needs Plans
- Condom Procurement for Clients on Medicaid
- Stress Reduction (Support Group Facilitation)
- Case Conference