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Elevating the Quality of Methadone Maintenance Treatment: An Interview with Dr. Howard Hoffman

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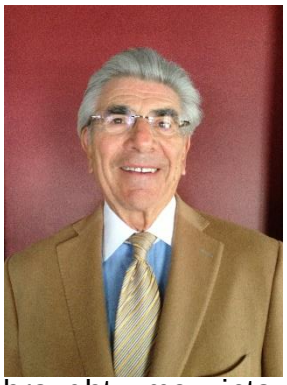

Introduction

During the past decade, interest has grown in increasing the recovery orientation of medication-assisted treatment in the U.S. My involvements in these efforts have brought me into contact with patient advocates, policy leaders and leading clinicians. Addressing the concerns being raised within these discussions touched on issues and involved recommendations that required testing on the frontlines of methadone maintenance treatment (MMT). It was in that context that Dr. Howard Hoffman and the senior clinical staff of his clinic agreed to participate in a series of studies aimed at enhancing the quality and recovery-orientation of MMT. In December 2013, I had the opportunity to interview Dr. Hoffman about his life's work and some of the advances he has made to the treatment of opioid addiction. Please join us in this engaging conversation.

Early History

***Bill White*:** Dr. Hoffman, your early background at NIH and Yale would have suggested a possible academic career specialization in research and policy. Could you share the story of how you came to specialize in frontline addiction medicine?

***Dr. Howard Hoffman*:** Well, it's been a circuitous route. When I finished my time at the NIH, I had an opportunity to go back to Yale and another opportunity to help a group that was starting a private psychiatric hospital in Washington, DC. I had learned at the NIH that the world of academia and research didn't have enough action for me so the idea of helping start a psychiatric hospital based on the research that we had done at the NIH sounded exciting. The research had focused on the therapeutic community as an instrument of changing psychotic behavior and it got noticed by a group of psychiatrists from George Washington University who were interested in trying it in real world conditions. So I began my work at the Psychiatric Institute of Washington.

A colleague of mine at the NIH, Dr. Robert DuPont, left NIH and went to work for the DC government to address the problem of heroin addiction in the criminal justice system. He started the first large-scale methadone program in Washington, DC and went on to become the first director of the National Institutes of Drug Abuse. As he was developing the city's large program, he asked me if I would develop a private methadone treatment program so that persons seeking treatment would have a private option. That was how I first heard about methadone and created what later became Partners in Drug Abuse Rehabilitation Counseling (PIDARC).

***Bill White*:** Could describe then the early history of PIDARC and how the program evolved during its early years?

***Dr. Howard Hoffman*:** PIDARC was a small program started in 1971 within the Psychiatric Institute of Washington. There weren't many treatment programs to speak of, certainly not in the private sector. This was a time when methadone was extremely controversial with much anti-methadone coverage within the media.

I hired a director who had been a heroin addict and was currently on methadone. Bob was a very charismatic person who grew up in Washington. He was a Golden Gloves Boxing Champion. His friends, for the most part, were inner-city boxing people and he got involved in the whole street life scene with heroin. He spent time in prison and when he came out, he got involved in the Man Alive Program in Baltimore. When he first came to treatment, he had no real interest in changing other than to use less heroin than he was then using. He was straightened out by that program's director, Richard Lane, and he indeed did turn his life around.

The patients felt a great kinship with him. Bob loved to tell stories, had a wonderful sense of humor, and had an easy way with patients. They knew that he understood them and he loved swapping street stories with them. So, he brought an absolutely unique perspective. I had had no personal experience with addiction. When I interviewed him, his only managerial experience had been running a shoe store for children. I said I would take a chance on him and he looked me in the eye and said, "I'm going to take a chance on you." And we started. He taught me a lot.

Bob took great pride in his larger involvement with the American Association for the Treatment of Opioid Dependence (AATOD). I will never forget him welcoming all the dignitaries to the first AATOD conference in Washington DC. He looked over the audience and said, "The last time I was in front of so many government officials, I got five to ten." That was Bob. He was key to much of what we did in those early years.

Bill White: And how did the structure of this program evolve?

Dr. Hoffman: The program grew slowly through those early years. In the '80s, I moved it to a non-profit organization called, The Foundation for Contemporary Mental Health, because I wanted it to have its own independent life so that if anything changed at the hospital, the program itself would have its own board of directors and its own infrastructure. Toward the end of the '80s, we decided to move and sever our ties completely with the Psychiatric Institute. I stayed on as the Psychiatric Institute Medical Director until 1991 and returned in 1995 and have continued to be involved there as Medical Director for the last 19 years. PIDARC, however, moved into a medical office building in the Foggy Bottom area of Washington, DC, not far from the State Department and the White House. That in itself has posed some significant challenges that we can discuss later.

***Bill White*:** To get our readers up to date, talk a little bit about the number of patients you currently treat at PIDARC and the number of staff you have.

***Dr. Howard Hoffman*:** PIDARC is our largest clinical program. We have a separate abstinence-based program for people

coming out of the criminal justice system. We're a 501(C)3, not-for-profit organization. We have thirty-two employees including counselors, administrative staff and physicians. PIDARC serves approximately seven hundred patients and we medicate close to five hundred patients a day.

Methadone Misconceptions and Controversies

***Bill White*:** Let me take you back a little bit in history. You referenced the controversy surrounding methadone maintenance, particularly in the early 1970s and I'm wondering if you had reservations about getting involved in methadone treatment given these controversies.

***Dr. Howard Hoffman*:** Well, I am generally publicity-adverse and very concerned that organizations I'm involved with fly under the radar, but with methadone, I felt such a strong commitment that this was the right thing to do that I didn't have reservations. Bob DuPont is the one that I give the credit for that. I have great respect, admiration and trust in Bob. When he was getting started, he asked me to consult to him and we went and visited Jerry Jaffe's program in Chicago and I came away just amazed with what they were doing there. And Bob had such grand plans for Washington. Those were the days when community psychiatry was in its ascendency and psychiatrists thought they could do anything from ending poverty to improving race relations. I was still naïve enough to think that that was true and, with Bob's charismatic leadership, I wanted to be a part of it.

***Bill White*:** At this late date in the history of methadone maintenance, what do you remains some of the most misunderstood aspects of methadone maintenance by the public, professionals and policymakers?

***Dr. Howard Hoffman*:** This is an enormously important area to me. Methadone maintenance has flown so far beneath the radar that it has almost divorced itself from mainstream medicine. It never ceases to amaze me how little physicians know about methadone maintenance. I get calls from hospitals and professionals just wondering what to do. Patients of ours going in for surgery on one hundred milligrams of methadone and having been clean for a years have their doses arbitrarily cut because the house staff have never heard of people on that high a dose and they're afraid of respiratory depression. We've had patients literally walk out of the general hospital because their dose was cut so dramatically and that they were beginning to go into withdrawal and nobody believed them. We've had people literally walk out of hospitals with lines in their arms. The prejudices and the lack of knowledge are just appalling. Judges, certainly probation officers, often have the misconception that the only way you know that somebody has made progress is if they're on nothing. This completely ignores all the data and the literature about long-term addiction and the changes in the brain and how the model of the illness has changed to one of a chronic medical brain disease. Patients often need a residential place to go, other than a shelter, and, still, many of the residential programs will say, "We won't take anybody on methadone," on the grounds that they're "not clean." I'm pleased to say we worked with Oxford House and they have changed their policy and now somebody on methadone who meets all the other criteria indeed can be a member at Oxford House. It's a small step but it's one we're pleased has taken place.

PIDARC Patient Profile

***Bill White*:** I want to explore the PIDARC program. Perhaps we could begin with a description of the very unique population of methadone patients served by PIDARC.

***Dr. Howard Hoffman*:** It is a surprisingly homogenous profile. When we started in 1971, the average age of our patients was about twenty-eight. The vast majority were male and African-American. Today, the average age of our patients is fifty-two and forty percent are women. They have, on the

average, more than three stretches in jail, having spent anywhere from five to twenty years in jail. It's also a sick population. A large percentage of our patients have HIV or Hepatitis C. It is a poor population and continues to be predominately African-American. We do have some middle class and younger white patients, but we get very few younger people entering treatment for the first time. We have a homogenous population of long-term addicts who know the street life, have had many treatment failures, and have come to us seeking a different kind of experience.

Treatment Approach

***Bill White*:** Your early vision was of wrapping medication-assisted treatment within the milieu of a therapeutic community. How has that evolved?

***Dr. Howard Hoffman*:** As our treatment experience evolved, it became clear to me that some of the things we were doing had all of the elements of the therapeutic community we had developed at the NIH. Staff at all levels had therapeutic potential, not just the doctor, so staff had to be empowered to use their skills and feel that they were a vital part of the treatment process. The administrative hierarchy had to be flattened for communication so that ideas and feedback at all levels were, not only allowed, but encouraged. And patients themselves were trained to be therapeutic instruments. These were all approaches drawn from the work we were doing at the NIH.

The therapeutic community notion is important because our patients spend a lot of time with us. They eventually earn weekend take-homes but for the first three to four months they're with us every day for one to three hours seven days a week. So everybody from our receptionist, who knows everybody by name, to the people who collect urines, to all the counselors who each know most of the patients, is part of this therapeutic milieu. When they walk in the door, they're in a safe, caring environment. It has a unique feel.

Many of our patients have come from other treatment programs where they felt either looked down upon or thought that the staff members were on a power trip. They sometimes felt that they had been dealt with in a demeaning or arbitrary way. We hear these stories over and over again. One of the things that I emphasize with our staff is the enormous power and control we have over our patients lives. We have to do everything we can to not abuse that power. When patients begin to trust that our focus is on care rather than control, it's a different experience for them. We've done a number of things programmatically to emphasize that.

In the early days, there were many rules we had that were a throwback from the old narcotic therapeutic community days—with lots of tough love and confrontation. We gradually evolved away from that, and we've done some interesting things to underscore the fact that our patients not only have a voice but they have implicit rights that we work very hard to respect.

***Bill White*:** I'd like to explore this therapeutic partnership that you emphasize at PIDARC. When patients first come in, how you do engage them into this new milieu?

***Dr. Howard Hoffman*:** This is something that has evolved over the past dozen years. We're always very concerned about patient retention and when somebody leaves the program within a month or two, it's clearly a failure of engagement in some way. I became very concerned about how we oriented patients. They come literally into a foreign country. PIDARC is a foreign country, we have our own language, we have our own rules and the patients come in from the streets with their own ideas of what they want from us. As you know, it's very difficult for patients coming from the streets to give up control and trust us.

When we started, there was no formal orientation. There was an intake, where the program is described and forms are filled out. I suspect many programs continue to do that. We felt we had to do something much more organized and systematic and so we

started what we call the Phase One group. This is an orientation group for all new patients who come once a week for at least the first four weeks of their treatment. I, with a counselor, lead two of the three groups we have. I start each group with a mantra and I say the same thing over and over each week because in the first week I know they're not hearing it and about the second or the third week when they've heard some of the words before, it starts to sink in.

First of all, I tell them we want to get to know them and make sure their methadone is holding them. We don't want them to be dope-sick because we know if they're dope-sick, they're not paying attention to anything we say. So we want to get them on the right dose as quickly and safely as possible. That's the very first thing I tell them and repeat it each week..

Second, I say that I want to give them an opportunity to ask questions about methadone, about the treatment, about our philosophy of care. We want to have an opportunity to teach them things because much of the treatment here is education. They need to learn that they have a physical illness--a brain disease. They need to understand the concepts of chronic disease and of relapse. I make a dramatic point by saying, "Our goal of treatment is not to get them clean. Our goal is to help them stay clean." They've figured out how to get clean and have done it many, many times, whether it's in jail, cold turkey on the street, or in a detox unit. Getting clean is not the issue. The issue is relapse and that's what we're going to work with them on: understanding the concept and all of the elements involved in relapse and that takes a long time because it gets to lifestyle. I say that in simple terms and I say it often.

Third, I say that our program has been around a long time and our data shows that if people can get off on the right foot, they have a better outcome. And everybody is there for the same reason and that is to avoid the misery that's waiting for them on the street again. And we don't want anyone to fail, so that we want to make sure that if they come in with their own agenda and it's going to come in to conflict with ours, we want to get that on the table from day one. We try to convince them that our way of thinking is the way that's going to work for them. Patients will come in for lots of different reasons and it's important to acknowledge that whatever reason they have, they're here. They've come through the door and we welcome them.

***Bill White*:** Dr. Hoffman, I'm also impressed by the lengths to which you'll go to keep people engaged in that process, even when they're struggling and having difficulties. Could you describe the stages of probation and the appeal process that reflect this kind of relational partnership?

***Dr. Howard Hoffman*:** Yes. It is very easy, as you know, to say a patient is noncompliant and to just taper them out and terminate their treatment. That's easy, but the program loses a patient whose life is then in jeopardy. So, we don't want to lose people but, none the less, there are rules and we monitor all drug use. We make it clear that if you're clean from heroin but you're using cocaine, you're dirty, and we've all got a problem. If you're using benzos and they're not prescribed, we've got a problem. If you're using benzos and they are prescribed and you're sedated, we have a problem and we want to talk to your doctor. We have a number of different ways to intervene.

First of all, if somebody is having a cocaine problem, we have a special track for people who are having cocaine problems. It's a ten-week group in addition to the rest of the program. The group meets weekly and they deal with cocaine, cocaine education, and their triggers for using. We have a similar one for alcohol because those are unique complications.

The patients who are non-compliant don't come every day. They miss groups. They continue to have dirty urines. When we've tried all the different interventions from individual to group to special tracks et cetera and they're still dirty, they may be placed on probation status. The patients know about this and it only occurs in a staff meeting. I would like to talk about our rounds because

I think that is also a very important and perhaps a unique way that we do things.

In rounds, a counselor can bring up that they believe a patient should go on Probation I. We discuss it and then a decision is made by all of us. When we've tried everything else and nothing has worked, the patient is placed on Probation I. That means that they attend a special probation group for thirty days once a week and they have thirty days to give us some clean urines. They come every day for meds and attend their special group. At the end of thirty days, if they have started to give clean urines, they then can come off probation or probation may be extended for 2 weeks if they are just starting to make progress.

If they don't come off and we don't extend and they're still giving us dirty urines, we then move them to Probation II. Probation II is much more serious in that they have only one opportunity to fail in the next month, one dirty urine, one missed medication, one missed group, and then they're put on a thirty day taper and discharged from treatment.

About two to three percent of our patients are on probation at any point in time. But we also began to look for alternatives to just ending treatment, for these least compliant patients., not just discharging them and telling them they could reapply for admission in 30 days. We decided to organize a new program that we call The Harm Reduction Program. This is for patients who have failed Probation II and are about to start their thirty-day taper out of the program. They're given an opportunity to try and save their treatment by volunteering to go into the Harm Reduction group. This is a separate program. It's located in the same building but on a different floor and this is what they have to do. They can stay in Harm Reduction for six months and sometimes more and they are not going to be put out for using. That's why we call it harm reduction. We're going to let them continue on methadone. However, we tell them, "You're no longer an official member of PIDARC. You're not going to work with your counselor. You're going to work with the person who runs the Harm Reduction Group and that means that every day at 11:00 am, you come to a group with others in that program. If you come to the group, you will get medicated after the group. The group has one function and that is to talk about whether you used yesterday and if so, tell us about it." And every person in the group has the same discussion. At the end of the group, when everybody has talked about what they did yesterday, they go down and get medicated. We take urines weekly but there is no pressure, so they're not going to spend a lot of time talking about their home life and what happened when they were children and all of that. We just want to know, did they use and what did they use and what were the circumstances surrounding their use.

If they give us five clean urines in a row, they then can resume their work back in PIDARC. They re-join their team, their home group and their counselor. They can stay in the Harm Reduction group six months and the pressure is off. At the end of six months, of course, if they're not regularly coming to the group, and they're missing meds and using, we say, "Look, you're not doing anything" and they may be tapered out.

***Bill White*:** I'm wondering what percentage of those people in the Harm Reduction Group you've been able to re-engage as full-time patients at PIDARC.

***Dr. Howard Hoffman*:** We first started the group in mid-2010. We recently took a look at the 88 patients who went into the harm reduction track. Of those 88, fifty percent successfully completed and returned to full patient status within PIDARC. We were absolutely astounded at that data. In our rounds when the counselor who leads that program would say, "So-and-so is coming back to PIDARC," all the other counselors would say, "I can't believe it. He's failed so many times, my God, I can't believe it." There then is great applause for what has happened.

***Bill White*:** That's wonderful! You also use an intervention process, and I'd like you to describe that if you would.

***Dr. Howard Hoffman*:** Yes. We have rounds twice a week with all staff and they are an extremely important part of the program. The way our rounds work is that we quickly go around the dozen or so counselors and check for orders—things like reviews for change in medication dosage or take home requests. That goes fast. Then, we go around again and everybody has a chance to deal with "issues". These usually involve a difficult patient and what we can do to address their challenges. I've emphasized to the staff that our job is to represent hope for change and so we always have to look for some kind of therapeutic grist to grab on to, some hook that we can work on that gives us something to move the patient forward. And we never know where that will come from. But occasionally, we come up with an impossible situation where the staff have run out of options.

So, two years ago, I said "You're telling me this patient is impossible. You're probably right. But, I want to have a chance to interview this person and see if I can learn something." So we then started what we call "an intervention". In the intervention, the counselor says to the patient, "Well, you're in trouble here and we're running out of things to do and the Medical Director of the program wants to talk to you and figure out what's going on." So, the patient comes in and all the staff are there. I make sure the patient knows who everybody is. I start by asking if they know why they're there. They usually have an idea and then I will start an interview and to look for something that we have not yet discovered about this patient and why they are doing so poorly. The fact that the staff member wants there to be an intervention as opposed to putting him on probation says something to me. It means that there's probably some spark of hope that we can do something as opposed to the patient who is so non-compliant that probation is requested. That's that two percent I mentioned.

Usually, the interview is about twenty to twenty-five minutes. Occasionally, we'll ask them to bring in a relative or a good friend. The patient has agreed to come so they're also wanting to look for some way out of the pickle they're in. I'm usually able to come up with something that we haven't tried before and I'll suggest trying it. The staff then has a new approach. Interventions have become a regular thing for us.

Recently, I wanted to see the impact of these interventions. In the course of close to three years, we have had 34 interventions involving 32 patients. Twenty-two of them remained in treatment and are clean, have made tremendous changes and now have now take-homes. Ten have continued to struggle but are seen as working the program. We were surprised and delighted by the data.

We then started having mini-staff interventions. When somebody would present a difficult case, I might recommend a mini staff intervention, where two or three counselors, each of whom knew something about the patient, would do an intervention with just them and the patient. We're not tracking data on those but it's become yet another way of dealing with the patients who might have been put out. All of this has contributed to increased patient retention and success.

***Bill White*:** I've heard you say before that the decisions made by staff can also be appealed by patients. Could you describe a little bit about that appeal process?

***Dr. Howard Hoffman*:** Yes. This is something that we started a number of years ago. And it gets to the heart of the enormous control we have over patients. We have tried to make it a much more egalitarian system. So, we introduced a grievance procedure where patients can appeal any decision that is made about them and their status in the program. That can be anything from losing take-homes to being put out of the program. Any administrative decision about them that they don't like, they can grieve. The way they grieve is they have to write a letter and present it to the Program Director. Then, in our rounds, the Program Director reads the letter and we then hear from the patient's counselor, their view of the grievance, the infraction that brought the grievance on, and then we discuss it. Sometimes, the

discussions are brief. Sometimes, they are very heated. Before I make the decision, we listen to everybody's point of view.

We've taken a look at the results from this process and found that a majority of these decisions are overturned in the favor of the patient's grievance.

***Bill White*:** And I would also guess that that process enhanced retention even among those patients where the decision went against them.

***Dr. Howard Hoffman*:** It has.

***Bill White*:** You've made references earlier to responding to dirty urines and made the distinction between prescribed versus un-prescribed drugs. How do you clinically manage the issue of prescribed benzodiazepines or prescribed opioids?

***Dr. Howard Hoffman*:** Those are the tough ones. If a patient is prescribed one of these medications, we will do unannounced pill counts to make sure that the number of pills that should be there are there. If they are not, then, that's a sanction for not taking them the way they are prescribed. We also send letters to the physicians first of all to make sure that all the physicians know the patients are also on methadone. In terms of benzodiazepines, we do let the physicians know that we discourage long-term benzodiazepine use. Most of the time, the benzos are prescribed by a family practitioner and we get good cooperation in wanting to work to taper the patient off of benzos. The medication issues have become more frequent and complex as our patients have gotten older and sicker.

***Bill White*:** You've committed PIDARC to evaluating key areas of clinical in collaboration with Dr. Robert DuPont. Could you describe how these efforts?

***Dr. Howard Hoffman*:** Given my research background, asking questions like that have always been interesting. We've not had the financial resources to devote to any kind of sophisticated research. However, Dr. DuPont and I have remained friends and over the years, we've talked about the possibility of some research collaboration. Bob has a research organization and has collaborated with us on a number of studies using our clinical data. Our counselors have now gotten training in collecting data and our Program Director, Bryan Chrisman, has also become very interested in looking at key clinical issues through a research lens.

Addressing NIMBY

***Bill White*:** PIDARC is located in one of the most prestigious and highest rent districts in the nation's capital. How on earth have you been able to pull off being able to site and maintain this location for all these years?

***Dr. Howard Hoffman*:** Well, that's a story that I am am quite proud of. We moved to our present location in 1990, so we've been here almost twenty-five years. We have two floors in a very nice medical office building located very close to a local university and next to a boutique hotel with the State Department on the next block. This is a very nice area and I tell the patients that they have a right to be treated with respect and in a medical office building, but that means we must maintain a good neighbor policy. And that philosophy goes back a number of years. The way that came about was that we had outgrown our original space and we needed to triple our size and there was some space available in the building so I contacted the owner of the building. He shocked me when he said, "Look, my job is to rent, but I can't rent more space to you because the other tenants have said that you're a nuisance. Your patients are loud. They have thrown coffee cups and cigarettes in the bushes and they have frightened other patients going to see their doctors or dentists." We had been there six or seven years at that time and I said, "This is the first time I have heard that. We want to stay in this location. It's pleasant and safe. I am going to see to it that our patients are not seen that way." So, I immediately installed some cameras to that we could see from all of our offices what was going on in front of

the building and in the lobby. I initially had a staff member out in front of the building every time there would be a major break in groups and during the peak hours of medication. The staff member's job was to say, "No congregation in front. No loud noise. No throwing things." The staff realized what was at stake. And we were given the space we wanted because that was the deal. I had talked to a member of our Board and was prepared to sue if they denied renting space to us because of who we were. But I couldn't do that if we literally were a nuisance, so I made sure that we were no longer were. And we got the space.

We improved our being a good neighbor by having a full-time staff member hired to be the Program Concierge in front of the building. He's out there from six a.m. until two in the afternoon. His job is to make sure that there's no double-parking in front, that there's no congregating, and that everybody behaves. And he doesn't do it just for our patients, he's become the concierge for the building so people getting out of cars going to any doctors, he will help and he'll make sure that the line to the parking garage is not overloaded and that there are no trucks in front. He's become literally the mayor of F Street. Everybody knows and loves him. That was one very smart thing we did.

We also have all of our patients sign a good neighbor policy where we outline all the do's and don'ts of what it means to be a good neighbor. In addition I got on the Board of Directors of the building. I didn't want anything to come to the Board that would catch me by surprise. I eventually became the President of the Board of Directors. It's a job nobody really wants to do. I do it, however, because I want to make sure that our program is safe where it is.

Career-to-date Reflections

***Bill White*:** Dr. Hoffman, let me ask one final question. What has been most personally meaningful to you in this work you've pursued?

***Dr. Howard Hoffman*:** Friends frequently ask me if I find working with chronically addicted patients. I've given that some thought because I haven't. What I have realized is that these people have so little. They're poor, they're sick, they're disadvantaged in every way you can imagine, and yet they come to us with a sense of hope and they don't want very much. They just don't want to be dope sick anymore. In my residency days, I assumed, as most of us did during the ascendency of psychoanalysis, that much of my outpatient career would be talking to interesting people. That would be fun. Well, it was for a short time, however, the personal gratification of working with a marvelous staff in this special mission and to see the gratitude of those we serve has been rewarding beyond measure. I thank Bob DuPont for introducing me to a field of medicine that as a resident I could never have imagined finding so deeply rewarding.

***Bill White*:** Dr. Hoffman, thank you for taking this time to share your experience with us. There are a number of pioneering innovations at PIDARC I hope to see widely replicated in the field. Thank you so much.

***Dr. Howard Hoffman*:** You're very welcome, Bill.

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