Methadone Today

The official newsletter of DONT–by patients, for patients **July 2006** **Volume XI Number V**

To State of Michigan Legislators--

Ending public funding of drug addiction treatment would be inhumane and

There has recently been discussion in the Michigan State Legislature regarding whether public funding (i.e., Medicaid) of drug treatment should continue. The only reasonable answer to this question is that public funding of quality drug treatment modalities should continue--and possibly be expanded.

We understand that the state budget is tight, especially in light of the economic difficulties that the State of Michigan is facing. However, eliminating or reducing existing state funding of drug treatment would be--to use the old clichè–'penny wise, pound foolish.'

Studies indicate that drug treatment actually results in a cost savings to the general public. That is for every dollar the public spends on addiction treatment, the public saves multiple dollars. In the case of methadone treatment, the return is especially high, roughly $7 in savings for every dollar spent.

Drug and alcohol addiction treatment works, and the public has an interest in supporting it, given the high monetary and social costs associated with addiction. Costs associated with drug addiction include law enforcement and the criminal justice system —the expense of arresting, prosecuting, and either incarceration or probation; medical care—the cost of treating diseases related to i.v. drug abuse, such as Hepatitis C and HIV and the costs of treating related medical problems, such as liver disease; and reduced productivity—the lost tax revenue if the addiction impairs one's ability to work and retain employment or while one is incarcerated for drug-related crimes committed to support one's addiction.

Thus, we ask that state legislators question the benefit of cutting public funding of drug addiction treatment. Any monetary savings to the state would be very short-lived. But not only would cutting funding of addiction treatment cost the public in the long run, it would reduce the quality of life for everyone in Michigan. The non-monetary consequences would ***(Cont. p. 4)***

Answer to Survey Questions--

One patient's report on his treatment provider

I am writing to answer the survey questions from this last newsletter. I started at this clinic three years ago, and they have made MAJOR strives in the right direction! I had actually contacted you about 2 ½ years ago for help as to what I could do to make my clinic a better place. My clinic had a rough patch with some REALLY BAD counselors and a nurse breaking the law, and I didn't know what to do! You told me who to contact, and I banded together with other patients, and reported them! Although the authorities didn't FORCE any changes, it was enough to get the attention of the clinic owners, and they cleaned house! I am happy to report that for the past two years my clinic has been a MUCH better place to attend. . . and I think they need recognition for making such wonderful changes!

Thank you to everyone involved in putting together this newsletter! You are doing all of us a GREAT service!

SURVEY QUESTIONS:

1. **Name:** WMTC (Woodbridge Methadone Treatment Center). It is owned by the Sellati family; they own SEVERAL clinics... I can only comment about the one that I go to.
2. **Location:** Manassas, VA
3. **Price per week:** $98 plus $10/week for UA's for new patients; this is waived for people with many take homes as long as they do not test positive for illicit drugs. I believe patients in OBT only pay $60/week.
4. **Highest Dose:** I do not have confirmation about this, but based on what I have heard in the waiting room from other patients, the highest dose is about 190 mg/d - 210 mg/d.

Average Dose: Again, this is just based on what I have heard from others, and does NOT include those people who are tapering, but the average seems to be 80mg/d - 100 mg/d.

5. **Highest number of takehomes allowed:** You can get 20 days (coming in once every 3 weeks), but after 3 years clean ***(Cont. p. 3)***

Explosion of Fentanyl Overdoses

The media has been reporting on a surge in fatal overdoses stemming from heroin and cocaine laced with Fentanyl. Overdoses related to the addition of Fentanyl to these drugs has been reported in various cities, but the largest number of deaths in the shortest time period occurred in Detroit.

According to the authorities and media reports, Fentanyl is being mixed into heroin and cocaine by dealers. Drug users were apparently unaware that Fentanyl was being added to the drugs--at least until authorities informed the media of the situation.

Fentanyl is an opioid many times stronger than heroin, and it is legally dispensed/prescribed in select cases for pain control. However, it is not prescribed on an outpatient basis very often, though it is sometimes used in chronic pain patients in the treatment of severe pain (i.e., in terminal cancer patients). As is the case with many of the stronger prescription opioids, it is relatively safe when used as prescribed under a doctor's supervision (e.g., the patient takes the prescribed dosage and does not take it in conjunction with alcohol, illicit drugs, contraindicated prescription medications, etc.)

But the risk of overdose is far greater when Fentanyl is illicitly sold for non-medical use. As with any illicit drug, the user has no way of knowing the dose s/he is getting, but in this case, the risk is multiplied because users do not know that what they are getting contains Fentanyl at all. According to authorities, illicit Fentanyl carries a greater risk of overdose of heroin. One of the more dangerous aspects of the Fentanyl-laced drugs is that users are actually taking a combination of drugs. In general, the majority of drug overdoses are caused by poly-drug abuse. Mixing drugs is far more dangerous than just taking one drug.

What can be done to eliminate or reduce the risk of overdose from heroin or cocaine mixed with Fentanyl? Obviously, the best way to avoid the risks of a Fentanyl-related overdose is for users to stop taking illicit drugs. This is about the extent of 'harm reduction' measures in much of the United States—that is, to tell users that drugs are dangerous and that they should quit taking them, but it isn't terribly realistic ***(Cont p. 2)***

Fentanyl Overdoses (from p. 1).

to expect everyone with very serious addiction problems to immediately quit using drugs, especially in a country where quality addiction treatment is only accessible to a small fraction of those in need of such treatment.

We believe that there are other measures that could be taken to reduce the probability of drug abusers fatally overdosing on drugs laced with Fentanyl. First, there needs to be a continuation of efforts to inform users that heroin and cocaine are being laced with Fentanyl--that many have overdosed from this combination, and it would help to explain the properties of Fentanyl and why the danger is so great.

Second, drug abusers need to be informed of how to keep themselves safe from an overdose. That means not only suggesting that they quit taking drugs and informing them of where they can obtain quality treatment, but also providing them with other ways they can reduce the risks, although users need to be aware that quitting drugs is the only way to ensure that they don't fatally overdose. It would be nice, though not terribly realistic, to provide drug abusers with a cheap testing kit that would detect the presence of Fentanyl in a drug sample. Beyond that, there are a variety of suggestions that can be made to drug users: Avoid i.v. use of drugs entirely or at least when first trying out a new batch; with a new batch, start out with a very small amount to see how much of an effect it is going to have; do not use drugs alone or have someone frequently check on you; and educate yourself and others about what to do in the event an overdose is suspected. Many lives are lost to overdoses because people do not know what to do and waste precious time doing useless things like putting the overdose victim in the shower or trying to walk him/her around.

Note that the government could make a difference by adopting the policy, which is already followed in Australia and elsewhere, that people will not be subject to prosecution if they call an ambulance for an overdose victim or take the victim to the hospital. Oftentimes fellow drug users do not promptly call an ambulance or rush the victim to the hospital because they are afraid that they will be prosecuted for being under the influence or in possession of illicit drugs or even held responsible for the overdose. Unfortunately, with some of these Fentanyl-related overdoses—-especially when the drugs were used i.v.—-the user died almost immediately. But even in the case of these Fentanyl-laced drugs, some overdose victims may be saved if people act promptly. Once the victim is at the hospital, the doctor can administer] an opiate antagonist that will almost immediately reverse an opioid overdose.

The surge in Fentanyl-related overdoses is a perfect illustration of the foolishness of governments skimping on funding of drug treatment—as well as driving out quality treatment providers with unreasonable regulations, including localities preventing the opening of methadone clinics, spurred on by 'Not in My Backyard' sentiments among residents. Even if people have no concern for the welfare of drug users and addicts, they ought to realize the multiple monetary and non-monetary costs associated with neglecting the problem—including the medical costs related to drug abuse and addiction. It is safe to say that not everyone who has overdosed on these Fentanyl-laced drugs has health insurance. . .and a large proportion of those without insurance are not going to be able to pay the emergency room bill for their overdose treatments. Even for those users that were pronounced dead at the scene, there are still costs that the public may have to incur (i.e., the dispatch of an emergency vehicle).

Many advocates question whether accessible drug treatment is even enough to reduce the harms associated with drug abuse. There is currently a discussion about whether the authorities waited way too long to go public about the surge in Fentanyl-related overdoses, and their belief that illicit drugs were being laced with Fentanyl. They seemed to have plenty of evidence of what was going on months before they informed the public of the potential danger, though authorities claim that they did not have sufficient evidence to jump to a conclusion, until recently when they did go public with this. There is still a widespread sentiment among the general public that drug abusers only have themselves to blame and should not be trying to hold the authorities responsible for the consequences of their illegal and risky behavior. However, we believe that there should be greater accountability—a lackadaisical attitude is not acceptable when one of the main arguments drug prohibition proponents make is that prohibition is necessary to protect people from the dangers of drugs. If protecting people from dangerous drugs is a major reason for prohibition, then the authorities should have been far more proactive at protecting people from Fentanyl if only by warning potential users that dealers were adding Fentanyl to heroin and cocaine, with disastrous consequences.

Alas, the government has an even greater responsibility to warn drug users about illicit drugs laced with a potentially deadly agent, since this problem is actually a consequence of drug prohibition in the first place! Clearly it is no coincidence that illicit heroin and cocaine are being laced with Fentanyl, yet the purity of prescription medications and alcohol are not an issue. Legal substances like prescription, over-the-counter medicines, and alcohol are legally regulated and monitored by governmental agencies. There is much less opportunity to adulterate or dilute these legal medications and drugs and much less incentive to do so by the companies that make them. Conversely, prohibition basically puts the manufacture and sale of products in the hands of criminal entities and increases the cost of the products to the point that it is very lucrative to dilute, add adulterants, or otherwise tamper with the products. Alcohol is a case-in-point. During alcohol prohibition, adulterants—including poisons—were added to alcohol. Occasionally, a drinker went blind or died from ingesting 'bathtub gin'.

Authorities believe that the Fentanyl recently/ currently being added to heroin and cocaine is being illegally manufactured and is not pharmaceutical Fentanyl diverted from hospitals or patients or otherwise stolen from pharmacies. As they have pointed out, Fentanyl (as well as most other mind altering drugs) can fairly easily be manufactured by someone with knowledge of chemistry.

Methadone Today would like to thank our Medical Advisory Board for their participation.

Our Medical Advisory Board includes:
Dr. Vincent Dole, Rockefeller University;
Dr. Marc Shinderman, Director/Owner of Center for Addictive Problems in Ilinois & Maine;
Dr. Andrew Byrne from New South Wales, Australia, who has written two books about methadone and addiction;
Dr. Brian McCarroll, Director/Owner of Bio-Med in Clinton Township, MI;
Dr. Charles Schuster, Director of the University Psychiatric Center in Detroit, MI and former head of NIDA; and his associate
Dr. John Hopper, Medical Director of UPC.

Answer to Reader Survey (from p. 1). time, you can apply for OBT, and that means you come in to pick up once each month.

6. **Amount of group/counseling:** When you are new to the program, you have group one time a week, and you must meet with your counselor for individual counseling once a week. After receiving one takehome and up to receiving a few takehomes, you must go to group once every two weeks, and an individual session twice a month. After receiving many takehomes you go to group once per month and have an individual session with your counselor once per month. After three years program compliance and acceptance into OBT, you come in once per month to meet with the doctor and pick-up your takehomes; you don't have to go to group or individual sessions anymore. Our clinic does one thing that is great. . . no matter how many takehomes you have, or even if you have successfully detoxed from the program, you are allowed to still come in for a group if you feel you need one. . . so they will continue to give support even once detoxed!

7. **Staff attitude:** MUCH better now! They have "cleaned house". All of the staff is now very friendly, respectful, and fair. . . just like a "regular" doctor's office. My clinic is a pleasant place to be, and everyone is aware of, and expected to comply with, the rules. Of course, there are a few patients who do not like to follow the rules and then throw tantrums when they are disciplined. . . but over all, my clinic is a good place!

8. **Waiting list**: My clinic does not have a waiting list, at least not that I know of. In the past year, the number of patients at my clinic has seemed to double! We have a TON of younger kids (18-19 years old) who are the new wave due to the Oxycontin problem in our area! (Manassas is the Oxycontin capital of the tri-state area.) But no matter how many new patients want treatment, it seems as if no one is turned away. . . which is GREAT! There is a "sign up" process at my clinic to deter people from simply entering treatment on a whim because they can't find a fix that day: you must call the confidential intake phone number, then go in to meet with the doctor (maybe a week to two week wait), and go to the lab for testing (maybe a day or two wait). Then, you come back to the clinic for your intake exam with the doctor (done only two times a week). . . you are dosed that very same day. The ENTIRE process can take as little as a week, or a much as three weeks.

9. **Additional Comments:** I have watched as my clinic has improved SO much in the past years: the program itself, the staff, and even the renovations of the office. . . all of the changes have made my clinic a great place to be! One change in particular that I think has been great is that they NO LONGER give observed urinalysis (UAs). This was always embarrassing and degrading; everyone dreaded them, because it was humiliating, and now it is a thing of the past! Instead, we now do our regular UAs as scheduled and then have to give random oral swabs instead of the observed UAs.

Of course there are a few things I would like to see changed:

*First, I wish that my clinic would offer later group sessions. Obviously more patients are in the weekly groups, and therefore they offer more groups to choose from for these people. . . you can pick from groups that start anywhere from 6 am to as late as 9 am. But there are few people that only come to group once a month. . . so there are fewer times to choose from. All of the monthly groups start very early—6:15 am to enable patients to get to work on time. However this is difficult for patients like myself who do not work the "typical" hours. I work late at night and have a LONG drive so when I have to come to group, I find myself only getting about two hours of sleep the night before! I feel this is dangerous because I have actually caught myself falling asleep behind the wheel! I think they need to make a later group offered once a month, allow for patients with these circumstances to do individual counseling in lieu of group, or allow them to come once a month to one of the later weekly groups. They don't allow this because the people in weekly groups are dealing with different issues than those in monthly groups, but something should be done. They have offered to work with me for a few months until I could change my work schedule, but I CANNOT change it. So at the moment, I am stuck but will hopefully get accepted to OBT next month!

*Set up a system for better communication with the patients. Every once in a while, there is the cause to cancel a group, cancel a scheduled doctor's visit, extend dosing hours, etc. For example, in the event of bad weather. . . we recently had a TON of rain which resulted in flooding. This made it impossible for some of the staff to get to the clinic. As a result, groups had to be cancelled for the day. The only problem was that because of the absent staff, no one was available to make calls to the patients to notify them of the cancelled groups. I myself did not find out about the cancellation until I had already been on the road for over an hour! I happened to call to say that because the bridge was flooded I was going to be running late and then was told of the cancellation. I wish that we had some type of phone tree system or that the clinic would get e-mail addresses for all of the patients and just send out a group e-mail, etc. Another idea would be for the clinic to set up a website that the patients could use to check for updates, changes, or other important information.

*More family involvement. There are SO many misconceptions about methadone! I wish my clinic would offer "family days" for new patients' families. Even if it was offered only once a month or four times a year, it would be a way to bring family members who have only heard the negative myths about methadone the chance to come in and learn the truth and the positive about methadone. This would be a positive thing for the patients as well! I think that my personal story is probably similar to many other people's story; when I started methadone treatment, I had to keep it a secret from EVERYONE because of the negative stigma attached. In the beginning I even had to keep it a secret from my husband (at the time my fiancé). Luckily for me, I discussed this with my clinic at the time, and they actually made an exception for me, and allowed ***(Cont. p. 4)***

State Legislators--Public Funding (from p. 4)

Methadone is the most effective treatment for opioid addiction; it is also the most studied. With methadone treatment, criminality decreases 57%, employment increases 24% and substance abuse is decreased by 70%. The CalTOP study agrees that spending taxpayer dollars on addiction treatment is a good investment. Further Zarkin, (2005, Health Economics) set up a lifetime simulation model which looked at ongoing or multiple incident methadone maintenance treatment (MMT) patients. The lifetime cost benefit ratio proved to be $1 to $38. For every $1 spent on providing MMT, society benefits $38.

We hope that you carefully consider all of the aforementioned issues before you decide whether to cut or eliminate public funding of addiction treatment. In light of the facts, we hope you too will conclude that drug addiction treatment funding is anything but an unnecessary expense.

Sincerely,

Detroit Organizational Needs in Treatment

State Legislators--Public Funding (from p. 1).

be higher crime, further overloaded courts and eventually more prisons. Then there is the perception of the State of Michigan held by the rest of the country. Does it really send the right message--that we would rather spend money to punish addicts than to make treatment accessible to them to at least give them the opportunity to get treatment before treating them as hardened criminals.

It is inhumane to not provide treatment for what is, in fact, a medical condition. The medical community defines drug addiction as a disease—a disease that is potentially very serious but highly manageable with appropriate treatments. As stated above, drug treatment ***does work***. Opiate agonist treatment (i.e., methadone or buprenorphine treatment) is highly effective—especially when patients are properly dosed. Once stabilized on an adequate dose of medication, most patients cease abuse of illicit and/or non prescribed drugs and alcohol. Programs such as Medicaid represent an effort to provide comprehensive preventive care and treatment of serious illnesses, diseases, and medical conditions to individuals who are eligible. Drug addiction is a serious medical condition, and it is inhumane to allow individuals to suffer with it who are unable to afford treatment themselves, but who are eligible for Medicaid, when effective treatments are available, especially when they are cost effective. **(Cont. p. 3)**

Answer to Reader Survey (from p. 3).

me to bring my husband into the clinic so that he could see for himself what it was all about and allowed him to meet with the staff so they could give him CORRECT information about the treatment. My husband now is a HUGE advocate of MMT. However after that, I was still forced to keep it a secret from the rest of my family for over a year! My family saw the positive changes I had made, and didn't know how I did it. Once my husband told them about my methadone treatment, they were VERY negative about it at first! That was VERY hard for me! I wished that my clinic had a family program that I could have brought them to so that they could have learned the truth about methadone.

*More praise. I wish the clinic had something set up to recognize the patients' accomplishments. I know that I felt more accomplished when I got my first takehome and when I had my first year clean, than I did when I graduated high school! I wish that the clinic would maybe once a month have a day that they would allow for patients who are interested to invite their family members to some type of congratulatory event—something that would give praise and recognition to the patients for working so hard. Many addicts have destroyed their families' trust, and I think that something like this may help to restore some of that trust.

Editor's Reply:

Thank you for writing in. It is important that patients like yourself take the initiative to write in about your methadone clinic/treatment provider, so we know whether various providers are really making an effort to improve treatment quality and respect patients' rights. We are glad to see that your clinic has made some great improvements since you last wrote us.

From the information you provide about average and maximum dosing, it appears that your methadone clinic is generally very good about adequate dosing; 80 - 120 mg/day is the effective dose for most patients. Of course, some may need higher or lower doses. There are still many methadone clinics who commonly underdose patients and even have dose caps.

However, there are certainly a few things about your methadone clinic that we take issue with. One is the waiting period required to start treatment. We believe that same day dosing of opiate addicts seeking treatment is very important, especially given the consequences of continued illicit drug abuse. To make an addict wait is an unfortunate lost opportunity.

Also, you definitely make a good point about flexibility of the group sessions being provided. Flexible hours should be an important feature of treatment providers--that goes for dosing hours, as well as for group and individual counseling sessions. Increasing functionality is one of the main purposes of drug treatment--that means having flexible enough hours to allow patients to work without having to leave early or start late to go to a clinic.

Another issue you raise is the apparent inability of your clinic to contact patients regarding cancellation of group sessions, etc. This is a common problem, and related to it is the lack of adequate emergency preparedness at methadone clinics. Few clinics seem to have contingency plans set up with their patients--and do not even instruct their patients on what to do in case of emergency. When a major power outage hit the Northeast U.S., we noted that many local methadone clinics were not answering their phones (they had voice mail systems that would not work without power), so many patients thought they were closed when they might not have been. Clinics need to get serious about emergency plans.

Beth Francisco, Senior Editor
Aaron Rolnick, Managing Editor
Methadone Today **(Vol. XI, No. IV)**
P.O. Box 90337
Burton, MI 48509-0337
http://www.methadonetoday.org
E-mail: bethfran@methadonetoday.org

DONT is a non-profit 501(c)3 organization dedicated to helping patients achieve quality methadone treatment, preserve patient dignity, provide greater public understanding, eliminate discrimination toward methadone patients, and promotion of harm reduction policies.

Won't you ***please*** help us cover costs of the newsletter, web site, etc. ***Your donations are tax deductible***.

IT DOESN'T MATTER WHAT OTHERS DO--IT'S WHAT YOU DO THAT COUNTS. PLEASE, *do your part*--GIVE WHAT YOU CAN.

This newsletter is made possible by subscriptions and donations only

- ❑ Single-copy ***patient/individual*** subscription to ***Methadone Today*** $20 yr
- ❑ DONT membership only - $10/yr.
- ❑ Subscription to ***Methadone Today with membership*** - $27 (save $3)
- ❑ Single-copy ***clinic/institution*** -$35 yr /9 issues - you may reprint up to 100/mo.
  - ❑ $50 yr. - to 250 copies/mo., contact us for other pricing
- ❑ Clinic subscription ($350/yr. - 100 copies/mo. will be delivered to clinic).
- ❑ Back issues - $10 each - Vol. I - X (or $35 all issues--Vol 1-XI to date)
- ❑ Donation of $_____ to send ***Methadone Today*** to someone who cannot afford it or to educate policy makers, clinic staff, etc.
- ❑ Enclosed are _____ 39-cent (or other) stamps to help with postage.
- ❑ Donation of $ _____ to the ***Methadone Today*** web site.
- ❑ Personalized, laminated methadone MEDIC ALERT card (send your name, clinic's name, clinic's phone number,& self-addressed, stamped envelope [SASE] - cannot be processed without preceding) - $5 with any order, $8 without order.

Name _____ **Phone:**_____

Address _____

City/State/Zip _____

E-mail: _____

For Medical Alert Card only:

Clinic Name _____**Clinic Phone:**_____