

Methadone Today

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"Not In My Backyard" --Opposition to Opening A Methadone Clinic Led by Grieving Mother

There is currently only one methadone clinic in the entire state of Tennessee. Advocates who reside there see a desperate need for more providers of opiate agonist treatment. In fact, the opening of a second opiate agonist treatment facility is long overdue.

The state government is finally permitting a second provider to open a clinic, but now Johnson City, the city where the facility is to be located, is fighting to prevent the clinic from opening. Some public anxiety and opposition is to be expected considering the stigma that still surrounds methadone treatment, but in Johnson City, the "Not in my backyard!" chorus is deafening.

One of the most vocal opponents of the clinic is a local resident, whose daughter had recently been found dead with methadone in her system (she was not in methadone treatment and apparently was not prescribed methadone by a physician). As is often the case with community resistance to methadone clinics, sentiment was primarily based on fear and emotion rather than fact. The woman essentially admitted that she knew nothing about methadone treatment and that her mind could not be changed.

Certainly, her daughter's death is tragic, but such an incident should not cloud the real issues. To varying degrees, all prescription medications have potential for serious harm--this is precisely why they are only legally available when prescribed by a physician. Her reasoning that methadone treatment should not be available because using methadone could result in death is based on a double standard --that opiate addicts are somehow less deserving of medical treatment than people with other medical conditions. Few people would approve of withholding pain medication from terminal cancer patients, even though opiate pain medications are potentially fatal and are responsible for killing more people than methadone does.

The fact is that methadone treatment is proven to be safe and effective. The inaccessibility of this treatment is a national disgrace. To withhold an effective treatment out of simple ignorance and double standards is unconscionable. (Cont. p. 4)

Discrimination Against People in Recovery Rampant, Advocates Say

By Bob Curly

Reprinted from Join Together Online (<http://www.jointogether.org>). Join Together is a project of the Boston University School of Public Health.

People in recovery face discrimination in the workplace, health care, and everyday life, and litigation may be the only way to force changes in some cases, experts told a panel convened at the annual meeting of the American Bar Association (ABA) in Washington, D.C., last weekend.

"Where are the lawyers?" asked Deb Beck, president of the Drug and Alcohol Service Providers Organization of Pennsylvania, who charged that managed-care firms routinely violate the minimum insurance laws on the books in 40 states, including Pennsylvania.

"Managed care has to be taken to task," Beck said. Pointing to efforts to pass laws requiring addiction to be treated on par with other health conditions, she added, "Parity won't solve that; it will be just another type of coverage to be denied. . . . We don't need parity; we need people to enforce the laws."

Beck was among more than a dozen advocates who presented testimony before Join Together's Policy Panel on Discrimination Against Individuals in Treatment and Recovery, cosponsored by the ABA.

"This is an issue I unfortunately have encountered from time to time, both personally and in my professional life," said Alfred P. Carlton, president-elect of the ABA. "We must work to end discrimination of any kind, but especially for people seeking treatment for addiction. It's a disease and should be treated as such."

Former First Lady Betty Ford said that while up to 80 percent of Betty Ford Center clients used to be able to pay for their treatment through insurance, today just 20 to 25 percent can access their insurance benefits. Not even lawyers are immune to addiction-related discrimination, she added.

When the Betty Ford Center recently tried to set up a residential treatment program for lawyers, doctors, and other professionals, nearby residents picketed and told clients (Cont. p. 3)



Dear Methadone Today,

First let me introduce myself. I'm a 44-year-old female who has been on methadone for three years now. Two and one-half of those years are "clean" ones.

My dilemma is with a clinic that's dispensing inadequate methadone. I've recently changed to a pharmacy that is good, but how does one deal with this matter? For the month that I was with this other clinic, I was in total torment--severe withdrawal--and when I politely inquired about my medication, that it just wasn't working properly, they would smile and comfort me as best they could, saying that they would personally administer my daily dose. Well, right there I knew something wasn't right. They also knew because I told them that I didn't use any other drugs. But it wasn't corrected, and I couldn't handle being sick all the time.

Did they ever stop to think of how many people's lives they disrupted or made fall away and use just to compensate for their inadequate methadone? This sure wouldn't have happened to a

diabetic and their medication or a heart patient's medicine. "Why," I've asked myself a hundred times, "would they do this?"

My husband got so tired of being at the mercy of the pharmacists that he weaned himself off of methadone. Both of us were fighting all the time because of withdrawal. We even went to the clinic and explained to them that their methadone was terrible and we were going to divorce over it! But to no avail.

I have to say that my husband is now six months clean from all drugs. To me it was a pretty crummy way to decide to stop such a life-saving medication.

I wrote all of this to show the severe B.S. we went through. I feel so bad for the ones who cannot change clinics and have to stay there. So I've decided to see if there's anything that I could do. It just makes no sense to me, and it is such an injustice.

Thanks for all the hard work that you put into each and every article. I enjoy them tremendously. -P. F. (Surrey, British Columbia, Canada) (Cont. p. 2)

Dear *Methadone Today* (from p. 1).

Dear P.F.,

We are always interested in hearing from patients in other countries regarding policies, regulations, and treatment practices. Unfortunately, we are not very familiar with the regulations regarding opiate agonist treatment in British Columbia, Canada. However, it is our understanding that within the last few years, the number of opiate agonist treatment facilities in Canada (or at least in some provinces--i.e., Ontario) has significantly increased. Hopefully then, fewer patients will have a choice of providers rather than having to choose between poor treatment and no treatment/detoxification.

You make reference to "inadequate methadone" and state that your husband was "tired of being at the mercy of pharmacists. . ." Without more information, we cannot be absolutely certain about the root of your problems, but most likely the problems were not in the dispensing of the medication or the quality of the medication itself. In our experience, it is only a small fraction of the time where the dosing nurse or pharmacist is responsible for such problems. Medication tampering by pharmacists, dosing nurses, or other clinic staff is uncommon but not unheard of. We find it unlikely that this was the cause of your problems. A pharmacist or dosing nurse could probably not get away for long with the degree of tampering that would have been required to put you and others in such serious withdrawal.

As for medication quality, in Canada, as in the United States, the purity and potency of prescription medications are regulated by the government. Put simply, any formulation of methadone on the market must contain the dosage of methadone indicated on the label, plus or minus a very small percent. As we have discussed in past issues, patients may notice some difference between one formulation and another. Because of differences in the inactive ingredients, the body may metabolize some formulations faster or slower than others, but this would not explain the problems you were having. And even if it could account for your problems, it would still be up to the clinic physician to compensate by adjusting your dosage or possibly trying a different formulation of methadone.

We find it likely that you were not being adequately dosed, and this would explain why your dose was not holding you. As mentioned in the previous paragraph, even if there were another explanation for your severe withdrawal symptoms, it is ultimately the physician's responsibility to remedy the problem. Clearly, no one at this clinic, including the physician[s], took your complaints seriously.

There should be a government agency and probably private watchdog groups as well to whom you can complain. If there is a formal complaint procedure available, use it. You and your husband are in an excellent position to alert authorities to this clinic's poor practices--since neither of you still obtain treatment from them, they are not able to pick on you for "blowing the whistle" on them.

Your letter illustrates that underdosing is a worldwide problem--though it may be more common in some countries/areas than others. The manner in which this clinic treated you and your husband is completely unacceptable. Hopefully, increased competition will force them out of business. Thank you for writing to us.

Study Reveals Progress in Methadone Dosing Practices

by Dr. Andrew Byrne, General Practitioner
(New South Wales, Australia)

**D'Aunno T., Pollack H.A. Changes in Methadone Treatment Practices: Results From a National Panel Study, 1988-2000. (2002) JAMA 288:850-856.*

The veteran methadone researcher Dr. Thomas D'Aunno has again performed a great service by examining dose levels prescribed in a variety of American clinics*. While many factors have been shown to influence outcomes, dose level has always been the most consistent predictor of positive outcomes. Methadone treatment started with a "culture" of high doses and a concept of "blockade" dosing. The original trials used doses of up to 180 mg daily and average doses of 90-100 mg (Dole 1965, Newman 1979) and there were few if any reports of serious side effects from maintenance doses. Conservative elements seem to have influenced dosing practices in the 1980s for some reason and only in recent years has the pendulum swung again in favour of effective doses, based on clinical criteria.

There are several recommendations that 60 mg is an approximate minimum effective daily maintenance dose for most opioid dependent patients. D'Aunno thus determined the proportion of patients in clinics (n>100) who were prescribed above or below this level from 1988 and at 2, 7 and 12 year intervals. Originally he found that only 20% of patients received 60 mg or more. This rose to 65% by 2000, which is most gratifying for those able to access treatment in the US. It must be a disappointment for American public health that although drug addiction has increased yearly, there has been little expansion in the numbers in treatment in the past 15 years.

The study also showed that clinics with higher proportions of African American patients prescribed lower doses but those with accreditation (and thus additional education) prescribed higher doses.

This study at last gives us a validated "standard" by which we can measure our own agonist pharmacotherapy practices. And it is clear that inadequate doses yield inadequate outcomes, including unsafe injecting. Of course this does not apply to every case and a proportion will be new patients or taking dose reductions, and thus may be appropriately treated on less than 60 mg daily. A minority of maintenance patients may also fare perfectly well on lower doses. In a "normal" practice sample, however, it would be expected that at least 65% were taking 60 mg or more for optimal results.

Editor's Note: We are troubled by the implication that African Americans receive inferior treatment--at least when it comes to proper dosage--to Caucasians. This begs the question of whether other minority groups receive inferior treatment as well. Certainly, more questions need to be answered--such as whether the problem is mainly that clinics with higher proportions of African American patients are generally inferior or that individual physicians are treating African American patients differently than other patients. It is possible that the discrepancy has more to do with socioeconomics than simple racism (e.g., in general, it may be the case that facilities in poor areas provide inferior treatment to facilities in more affluent areas). Regardless, this issue requires further study. We can only hope that accreditation (all opiate agonist treatment providers must now obtain accreditation, per the new federal regulations) results in better treatment, eliminating this discrepancy in dosing practices.

As reported in the (August 20, 2002) Reuter's Health article, "Methadone Care for Addicts found Lacking," the study's findings are not all good. While significant progress has been made since 1988 in dosing practices, "recent studies have shown that the optimal dosage required to block heroin cravings is more than 80 milligrams of methadone per day, and only about one-third of patients are receiving this amount the study findings indicate. 'Increasing dosage levels to 80 (milligrams a day) may be the most pressing current issue, in light of recent clinical evidence and in light of increased heroin purity of street drugs,' the authors write."

Dear Methadone Today (from p. 1).

to go home. "They threatened to videotape our patients going to and from the homes and make public their tapes," Ford testified. "The ignorance and hate were surreal. A few residents stood up and spoke in our support but were shouted down. So, the Betty Ford Center, maybe the best-known treatment center in the world, has to find alternative housing for our patients. "NIMBY is alive and well in 2002," said Ford.

Robert Newman, M.D., director of the Baron Edmond de Rothschild Chemical Dependency Institute at Beth Israel Medical Center in New York, said that people with addictions are "subjected to conditions that would be unthinkable in any other medical practice," such as having their medication levels capriciously reduced or eliminated or being told to deal with their problems through behavior modification rather than medical intervention.

"You're talking about horrid malpractice of medicine," said policy panel member Lisa Mojer Torres, a New York attorney who represents clients with opiate addictions.

Brent Coles, the mayor of the city of Boise, Idaho, agreed. "When you have a 16-year-old with a chronic, acute disease, we would have to find her treatment if she had diabetes," he said. But 90 percent of Idaho cities offer residents no access to treatment, said Coles. Even Boise, with its 200,000 residents, does not have a single detoxification center, he said.

"Eighty-five percent of narcotics addicts in US have no access to methadone treatment," added Newman. "My doctor can treat a patient for pain relief with methadone, but if he does so for addiction, it is illegal."

Newman said that the only hope for fighting such discrimination is through litigation.

'Hysterical Terminations'

Having a drug arrest on your record or a history of addiction also dogs people in recovery in the workplace--even after years of sobriety.

Susan Rook, Director of Communications and Outreach for the advocacy group Faces and Voices of Recovery, said a recent Peter D. Hart survey found that one in four people in recovery have experienced discrimination in the workplace or in seeking health care, and one in five fear being fired if their employer finds out they are in recovery from addiction.

Citing a pattern of "systematic and illegal discrimination against people who are in recovery," Rook said, "When personal prejudices influence my ability to get a job, receive an earned promotion, get and keep health insurance, life insurance, housing and other basic benefits of being a member of a

community--then someone else's opinion of me matters. And that personal prejudice is not merely stigma. . .[its] discrimination."

Rook stressed that despite the risks, it is important for people in recovery to speak out against violations of their basic civil rights. "It's not just about what other people say but what those of us in recovery don't say," Rook testified. "The public silence of people in recovery speaks volumes. Our silence says to others that we have something to be silent about. By our silence, we let others define us."

Adele Rappaport, a lawyer in the Detroit office of the Equal Employment Opportunities Commission, said that people with addictions are frequently the target of "hysterical terminations." She told the story of a client who told his employer that he needed addiction treatment and instead was fired for violating the company's zero-tolerance policy. "What kind of personnel decision is that?" she asked.

Unfortunately, the Americans with Disabilities Act (ADA), which ostensibly provides some protection for people with addictions, provides little help. Rappaport estimated that 95 percent of people with addictions fail to meet the ADA's standard for disability (e.g., impairment of a major life function), while others run afoul of the law's exclusion of coverage for current users of illicit drugs.

Nonetheless, addiction remains the most common personnel problem in most workplaces, accounting for 20 percent of voluntary employee-assistance program referrals and 50 percent of supervisory referrals, according to Dorothy Blum, Vice President of the Employee Assistance Professionals Association. Employers should be warned that discriminating against people with addictions not only will harm their bottom line in the long run but also opens companies up to litigation, said Blum.

The workplace woes experienced by people with addictions are compounded in many cases by a criminal record, which makes finding a job even more difficult.

"Many ex-offenders with drug-related offenses are also currently in recovery or treatment. Logically, their ability to truly recover and move on in their lives is directly connected to their ability to obtain and maintain employment," said Robin Runge, coordinator of the program on women's employment rights at the D.C. Employment Justice Center, during her testimony before the policy panel.

But Runge, who works with ex-offenders trying to get jobs, said having a criminal record is often the primary barrier to employment for people in recovery--especially with the increase in the use of criminal background checks after 9/11.

"For example, I had a client who was a teaching assistant in the D.C. public schools for over a year when a background check showed that she had been arrested over 20 years ago for drug possession," said Runge. "Although the employer knew about this arrest when she was hired, they used this background check as a basis to fire her."

In a recent survey, 59 percent of California employers said they would never hire anyone with a felony drug conviction--even though such discrimination is illegal in most cases.

"We need to help employers understand that hiring someone with an arrest from 10 years ago is no more risky than hiring someone without a criminal record," said Runge. "In fact, they may find that the employee with the record is harder working and more committed."

Editor's Note: The ADA only covers discrimination by employers and in the public sector [government]. Thus, the ADA does nothing about many areas where discrimination is rampant--for example, when it comes to health and life insurance. Individuals who have to purchase their own health insurance will pay far more money for a policy if they suffer from drug addiction or certain other maladies.

Unions May Provide Protection Against Discrimination

Often, union shops provide protection against discrimination. In some cases, the union contract will provide legal protection where the ADA does not. In addition, the union grievance procedure may be more expedient than going to court over a violation of the ADA--not to mention, much cheaper.

In contrast to the story related above of an employee who was fired when he admitted to his employer that he needed addiction treatment, unions often protect employees who admit they have a problem requiring treatment. However, a union contract is not going to shield an employee from discipline if he is intoxicated during work hours.

In some cases, union contracts will specifically mention an issue like addiction/substance abuse, and how certain scenarios will be handled. If not, most companies have a written policy regarding substance abuse. If the employer's actions contradict their written policy, the employee may be able to file a grievance.

Thus, if you do happen to work in a union environment, make sure that you know all of your rights under the union contract.

Not In My Backyard (from p. 1)

Methadone treatment also benefits society in the form of reduced crime and increased productivity. Furthermore, if saving human lives is the issue--one methadone patient advocate has pointed out that far more people will die because methadone treatment is inaccessible to them, then the small number of people who die from a methadone overdose [or where methadone is/may have been a contributing cause of death].

Meanwhile, the local officials fan the flames in order to score political points. Worse perhaps, not one local physician came out in favor of allowing the clinic to open [at least according to the City Commissioner, one of the clinic's opponents]. The head of the East Tennessee State University's College of Medicine indicated that the college was unequivocally against the clinic and accused the clinic of exaggerating the need for a methadone clinic in the area.* Not one prominent resident or local group advocated in favor of the clinic. An Administrative Law Judge is going to hold a hearing on this matter sometime in December, and issue a decision based on his findings.

At one time, there was basically no recourse for methadone treatment providers who were shut down or prevented from opening by the local government, but this changed with the passage of the Americans with Disabilities Act (ADA). The ADA provides protection from unreasonable local laws/ordinances. However, the ADA is not currently at issue in the Johnson City case, since the decisions and rulings are being made at the state, rather than the local level.

Methadone Today will report on the final outcome of this dispute in a future issue.

Study: "High" Dose Treatment Does Not Increase Complications in Pregnancy

**All quotations and information regarding the study is derived from, "Pregnancy not a contraindication to 'High' Doses of Methadone Maintenance Therapy," OB GYN News, Section No. 16, Vol 36; P. 10 - ISSN:0029-7437 (August 15,2001).*

Methadone Today has dealt with the topic of pregnancy and methadone maintenance treatment in various issues. It has been well established that detoxification is unsafe for the fetus during pregnancy. Methadone patients should continue a maintenance regimen. Nor is decreasing the patient's dosage recommended. As a matter of fact, many pregnant patients require a dosage increase later in their pregnancy, "[p]erhaps due to changes in maternal metabolism during the third semester."*

Methadone maintenance does NOT increase the probability of birth defects, complications, etc. A percentage of infants born to methadone maintained mothers do experience some degree of opioid withdrawal symptoms, though these can be humanely and safely managed by the attending physician.

A 2001 study (Dr. Peter Selby) added to the body of evidence that decreasing the patient's methadone dosage during pregnancy is unnecessary and, in fact, endangers both fetus and mother. The study compared two groups of pregnant methadone maintained patients--one group whose daily methadone dose averaged 64 mg and the other group whose daily dose averaged 132 mg.* Dr. Selby found that, "[t]he infants of the two cohorts had no significant differences in birth weight, length of hospital stay, or incidence or duration of neonatal withdrawal."*

Yet, not all methadone clinics have gotten the message that for pregnant patients, lower methadone dose is not better. By not providing an adequate dose to these patients, clinics are putting them at increased risk of a relapse, with all the potential dangers this entails. The problem of poor treatment during pregnancy is exacerbated by the limited choice of treatment providers--many methadone clinics will still refuse to treat pregnant patients, instead transferring them to a clinic that will. Hopefully, methadone patient advocacy efforts to educate clinics, along with accreditation will improve the quality of treatment provided to pregnant methadone patients.

Medication Alert:

Long term use of hydrocodone in combination with acetaminophen (aka: Tylenol) can cause hearing difficulties. Many doctors are not aware of this and do not make the link between the patient's hearing problems and hydrocodone use until it is too late. If an individual having such hearing problems continues using hydrocodone with acetaminophen long enough, permanent/irreversible hearing loss may result.

Hydrocodone is an opiate generally used to treat moderate pain. Hydrocodone is the main ingredient in several prescription products, many of which also contain acetaminophen (i.e., Vicodin). The risk of hearing loss only exists when it is used long term. In most cases where hearing loss occurs, the individuals were taking fairly large doses for an extended period. For this reason, people who become addicted to hydrocodone are at greater risk of developing such hearing loss.

-"Rapid hearing loss--a side-effect to overuse of a prescription pain-killer," Combined Otolaryngology Spring Meetings, Apr. 25, 1999.

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