

Methadone Today

The official newsletter of DONT--BY PATIENTS, FOR PATIENTS October 2003 Volume VIII Number VII

Blackout Disrupts Methadone Treatment

The large scale electrical power outage in August, which affected a large portion of the Northeastern United States, put the emergency plans of methadone clinics to the test. In some ways, this particular "emergency" was more difficult for treatment providers to deal with than the emergency situations they were used to dealing with. The typical severe thunderstorm, tornado, etc., only causes problems like power outages on a very localized basis--in an area like southeastern Michigan, which has many methadone clinics, treatment providers should be able to handle such events by sending patients to another methadone clinic which still has power, etc.

Treatment providers in coastal areas have had to deal with hurricanes, which may cause more widespread problems, but at least with hurricanes, they usually have prior warning. In such cases, wise providers have given a small supply of extra take-home medication to patients that should last until the emergency has passed. With other "natural" disasters, like blizzards, it may be possible to deal with them in this manner, even if they are somewhat less predictable than hurricanes. So, unlike most emergency situations that methadone treatment providers are used to dealing with, the massive power outage was not only widespread in scope but also came without prior warning and, therefore, was impossible to prepare for.

One complicating factor is that the majority of methadone clinics dispense liquid medication via a computerized pump system. In such cases, doses can be dispensed manually, but doing so can be a slow process, especially when one is not used to it. Methadone clinics that do not dispense medication using a computerized pump system certainly have an easier time operating without power, even though they do normally require computers to provide patient information (i.e., dosage, take-home schedule, etc.). Though this was a nuisance for patients and provider staff alike, this was not one of the more serious issues. Since most businesses, except some retail stores, were closed during the outage, patients generally did not have to worry about being late for work if dosing took a long time.

An issue that was apparently overlooked by most methadone clinics (at least in southeastern Michigan), (**Cont p. 3**)

Why is Methadone Maintenance Such a Controversial Treatment?

by Marc Shinderman, M.D.,

Center for Addictive Problems (CAP), Chicago, Illinois

Reprinted from CAP's website at <http://www.capqualitycare.com>.

Common sense, personal experience and prejudice are the customary resources called upon by those finding fault with methadone maintenance treatment. The controversy is due, in part, to the apparent contradiction in the concept of treating addicts with what is erroneously regarded as an "addictive drug." While methadone can treat addiction, and chronic use can create physical dependence, methadone "addiction" does not, in realistic terms, exist. When patients relapse, they do so with short-acting opiates, such as heroin, morphine and oxycodone but **not** with methadone. Because of methadone's slow onset and long duration (days) of action, it is rarely sought out by addicts or non-addicts in search of a drug "high." By the time someone seeks out methadone, he or she has already suffered the brain disease, which underlies true opioid addiction. Fortunately, 30 years of relentless, uninformed attacks on methadone maintenance have resulted in its becoming the most thoroughly scrutinized and researched substance abuse modality in history.

Some who have experienced long-term recovery from abstinence-based "treatment" or 12-Step fellowships are unable to comprehend just how lucky they are; they do not realize that most opioid addicts will not be so fortunate. Addiction is a disease like any other. Addicts with a less severe form of the illness may not need medicine, like the diabetics whose disease responds to losing weight and who do not therefore, require oral or injectable medications. The safest and most effective treatment for most opiate addicts, however, involves support and structure along with medications which eliminate cravings and protect patients from overdose. For most heroin addicts, for example, heroin and other addictions last for a lifetime according to a 2001 research article.

While this may be obvious to most, it is threatening to the world view of some, such as abstinence worshippers or others, whose brand of recovery compels persecution or shunning of methadone maintenance patients. No amount of (**Cont. p. 3**)



Dear Methadone Today,

I am a former patient of a methadone maintenance treatment program (MMTP) who detoxed, went to school to become an LPN, and am currently working at an MMTP. My co-workers do not know that I am a former patient, but my patients often tell me that I treat them with more dignity and add that, "they can't put their finger on it," (why I am so different than the other nurses). I usually reply, "I wasn't always a nurse."

One of the hardest things that I experienced after detoxing was the inability to sleep. I joined a gym and worked out after work. When I reached home, I would shower and relax. This, after two to three weeks, helped me to sleep. Once my life stabilized, I returned to school to complete the education that had fallen to the wayside during my drug use. After three grueling years, I completed my prerequisites, my clinicals and, finally, the state boards to become a Licensed Practical Nurse.

The reason I chose Chemical Dependency Nursing is because I know what it is like to be on the other side of the window (patient). I

figure that the journey to a drug-free life is difficult enough, and the patients need a genuinely caring nurse who knows just how hard that journey is. If I can give encouragement and love along the way... then I'm a happy nurse in NYC. **-Anonymous**

Dear Happy Nurse,

Congratulations on your career and hard-earned success in treatment. You should be commended for going to work at an MMTP and treating patients with respect and dignity. Of course, all staff should do the same, but not all do. In any case, the patients you treat surely benefit from a nurse who really cares and can empathize with being a patient receiving an unfairly stigmatized treatment.

Speaking of stigma, we should point out that "detox" is an inaccurate term. Detox leads people to believe that methadone is somehow toxic or harmful. Therefore, we prefer to use a more accurate and neutral term, such as "withdraw" or "taper".

Thank you so much for writing in, and keep up the great work.

Dear Doctor,

I was a heroin addict for more than seven years. I live in Zagreb, Croatia, but I don't know anyone to help me around. I'm pregnant for more than seven months—actually 32 weeks. I'm taking methadone treatment since before I knew I'll have a baby. Daily dose was 75 mg of methadone in the beginning. Everybody frightened me that it is so wrong for the baby, and I decided to take off the methadone as fast as I can.

It wasn't easy, but I manage it somehow. Then, there was a crisis when I get back on higher dose. Now I'm on 40 mg some days. Some days I manage to survive with only 25 mg. Those days when I take higher dose, I don't feel my baby that strong, like the days when I'm on less mg of methadone. Can you tell me Doc, is my baby girl suffering because of that?



What bothers me also is that some days I cannot help myself from sniffing the methadone. How can that affect my baby? Those days, I need a higher dose than 25 mg of methadone. I would really like to stop taking methadone.

What worries me now is how to take off methadone a month before baby is born. Croatian experts in addiction field told me if I stop using methadone one month before baby is born, baby wouldn't have withdrawal syndrome at all. That is what I want, and I beg you to

help me how to accomplish that without hurting my child. I'm taking also three times per day 2 mg of diazepam.

In my country, addiction problems are really important, but it seems like only few people care about it. I'm scared to death if I cannot get off methadone before my baby is born 'cause in hospital treats women like me like animals. They do not allow you to breast feed your baby.

I really want to take off the methadone because of myself, 'cause I hate to be addicted of anything anymore. I have a loving husband who was never an addict but understands me more than anybody. And the last, but not the least, I do like my life that is coming soon, and I'm looking forward to be a mum. And I do not see myself like an addict anymore!

Would you please help me how to take off the methadone? My term is first of October 2003, so I have to be clean first of November! (**Note: letter was written and replied to in the beginning of August.**)

Thank you very much in advance!

Sorry, I know my English sucks, but I hope you understand most of my mail. - **Mother-to-be**

Dear Mother-to-be:

Most experts would say that you are putting yourself and your baby at high risk by getting off of methadone. I am forwarding your letter to people who may have a better understanding of your situation, in Eastern Europe. Perhaps they will communicate with you.

You have been given some very bad advice. Withdrawal is not healthy for the fetus at this stage, and you will probably relapse to heroin or illicit drug use once you are off and under stress. As an active addict, you put yourself and your family at risk. I recommend that you stabilize on a dose of methadone that makes you feel comfortable.

Marc Shinderman, M.D.

Center for Addictive Problems (CAP), Chicago, Illinois

Editor's Note: While we only rarely, if ever, receive correspondence from patients or staff in Eastern Europe, we are aware of the very serious challenges opiate addicts face when seeking treatment in many former "Eastern Block" countries. However, we urge readers not to lose sight of the fact that U.S. methadone patients are often subjected to the same sort of misinformation and discrimination—even at the hands of medical "professionals".

Finally, we should make clear that methadone treatment is in no way harmful to a developing fetus. Some newborns do experience withdrawal symptoms, but many do not—and the dosage the mother was on before birth does not seem to make a difference; if the baby does exhibit withdrawal symptoms, medication may be given to relieve discomfort, and the child does very well. Otherwise, babies born to methadone maintained mothers are as healthy as any other baby. These babies are not more prone to medical disorders or birth defects than the general population.

Given the present situation regarding stigma and discrimination against methadone patients by many medical professionals, we would suggest that methadone patients educate themselves about methadone treatment, as well as other medical conditions or circumstances that arise, and ALWAYS get a second medical opinion if at all possible.

Dear Dr. Byrne,

As you may be aware, much of the Southeastern portion of the U.S. and some of Canada experienced a major electrical power outage in August. The power outage caused serious problems for methadone patients getting dosed. Concerned patients who called their methadone clinic to find out whether it was open and what they should do got no answer to their call. Apparently, automated phone systems went down when the power failed, and clinic staff could not pick up the phone and answer calls manually. This left patients wondering where to go and whether they would be dosed or not.

Also, many patients attending area clinics commute a long distance, including those from a neighboring state that doesn't have methadone maintenance. The power outage rendered traffic lights inoperable, making for a slow, dangerous commute, and if their vehicle ran out of gas, virtually no gas stations in the outage area could provide fuel. Finally, most area methadone clinics dispense liquid medication via computerized pump system, so they had to resort to manually measuring out doses—which took forever.

It seemed to me that the majority of the methadone clinics in my area did a poor job of emergency planning, although I do have to commend them for making sure their patients were dosed.

How do Australian methadone treatment providers plan for and deal with such emergency situations? Does allowing patients to dose at local pharmacies relieve some of these problems? -**N.J.**

Dear N.J.,

Oh yes, the problem of contingency planning for emergencies is crucial in all medical services. We first addressed it all in response to the alleged and much feared 'millennium' bug. In fact, it never materialized, but (**Cont. p. 4**)

Blackout (from p. 1).

was what a power outage would do to the telephones. Increasingly, methadone clinics, like other businesses, have switched to an automated phone system. The caller hears a recorded set of messages which instruct him/her to press a certain number or extension, depending upon whom they want to talk. Most of these systems do not work if the power is out.

Frantic patients, calling their methadone clinic to find out whether it was open during the power outage, got no answer. In particular, this presented a problem with multi-site treatment providers where patients had no way of knowing whether they were to go to their usual site or the provider's main site.

This was no small matter during the power outage when navigating streets with inoperable traffic lights made driving slow and very dangerous---and if the patient did not have enough gas in his car to go to two different clinic sites, he may not make it to the second site. Gas couldn't be bought/pumped at most gas stations. Thus, patients should be instructed as to which site[s] would be open in a widespread emergency and, if possible, an extra phone should be available to plug in before the a u t o m a t e d

phone system so that calls could be manually answered during a power outage. One good way to assist patients in the event of an e m e r g e n c y , would be to give all patients a small printout, e x p l a i n i n g

emergency procedures, and what the patient should do in the event of various emergencies. For example, the printout may contain two different phone numbers to call in the event of an emergency. In case the phones are down at one site, the patient could call the number at an alternate site where the phones may be operational and get specific instructions regarding where to go to be dosed.

The handout might have specific instructions in case the provider could not be reached by phone: which clinic site the patient should go to and specific directions for getting to that site. Such a printout would not take a great deal of time or money for a treatment provider to create and would have reduced the confusion and complications during the power outage.

The good news that came out of this emergency was that one way or another

patients were dosed if they made it to their clinic. Methadone clinics using computerized pump systems manually measured out doses. This was time consuming, but most nurses came to work despite driving on roads that were sometimes dangerous and worked extra hard to dose all patients who attended. We would like to thank the clinic staff members who toiled during the outage--under such circumstances. It is easy to forget that after working extra hard at a clinic, most of you had to go home and deal with the power outage like the rest of us.

It does not take an event as drastic as a terrorist attack to wreak havoc on a methadone clinic's routine. Not to overgeneralize, some treatment providers have done a very good job of preparing for emergency situations, but methadone treatment providers need to put a lot more effort into planning and preparation for various emergency scenarios.

The need for careful preparation cannot be overemphasized. Even a simple strategy like sending patients to another methadone clinic to be dosed requires preparation, as finding another methadone clinic to take the treatment provider's patients does little good

Does your clinic treat you right?
Bio Med treats their patients with
dignity and the respect they deserve.
22900 Remick Drive, Clinton
Township, MI (586) 783-4802
Near Metro Pkwy (16 Mile) & Gratiot

if the methadone clinic doesn't have enough extra medication to dose the treatment provider's patients. Hopefully, treatment providers will now take a good hard look at their emergency plans, remembering that it is very stressful for not only clinic staff but for patients who need this life-saving medication.

Controversial Treatment (from p. 1).

scientific study or medical expertise will convince such people of the therapeutic value of MMT; once they assign a negative moral value to the treatment, they have no further need to listen to the results of scientific research. **Facts are never an answer to religious belief.**

We now have decades of treatment experience and mountains of research* that prove methadone maintenance to be the safest, most effective treatment for heroin

addiction that exists (Institute of Medicine (1990). *Treating Drug Problems, Vol. 1*). In 1997, the National Institutes of Health Consensus Panel of experts found methadone maintenance to be more effective and less dangerous than *any* abstinence-based treatment, whether 12-Step, hospital inpatient, therapeutic community or "faith-based." More recently, data collected regarding rapidly "detoxified" patients and others treated with naltrexone (a medication which blocks any effect of opiates, guaranteeing a state of "abstinence") showed eight times the death rate that occurs with methadone maintained patients and nearly twice the rate occurring in untreated heroin addicts.

*See CAP's web site for research supporting this article's medical statements.

www.capqualitycare.com

Besides being safer and more effective, methadone maintenance is less intrusive, more confidential and less costly than most other "treatments." Methadone is not "just another drug of abuse." It is a medication proven to be unsurpassed in restoring neuroendocrine balance in addicts, when compared with heroin and other short-acting opiates.

For those with an open mind, methadone maintenance can be compared to the use of insulin treatment for diabetes. Most patients will need it for many years and some, for a lifetime. Counseling with addiction or diabetes to avoid substances and behaviors that are not healthy for their condition is fine, but when there is too much sugar in the urine of a diabetic or illicit heroin is present in the urine of an addict, it is the ethical responsibility of the physician to prescribe or increase medication which can predictably stop the damage to the patient's health caused by behaviors which do not respond to counseling and advice. Methadone has side effects which make some patients physically uncomfortable, fatigued or otherwise dysphoric. It is not suited to every patient; no single treatment ever is. All clinical research to date does tell us that methadone maintenance represents the best chance for health and long life for the great majority of opioid addicts.

Editor's Note:

Dr. Marc Shinderman is the owner/Medical Director of CAP---a top-notch methadone treatment provider, with two clinics in Illinois and one in Maine. CAP's web site is an excellent source of accurate information about opiate addiction and treatment and other substance abuse treatments.

Patient Editorial: Accreditation system solves no problems and yields few benefits

It seems to many of us patients and some of the providers as well that this attempt to legitimize the business of administering methadone to those of us who are trying desperately to get our lives back on track has only created a financial and paperwork nightmare. Forcing methadone clinics to adhere to CARF or JCAHO (groups that deal primarily with hospitals) guidelines does not improve delivery of service to patients or providers and in many cases has forced many addicts who were functioning well on methadone back to the streets because of the increase in fees. I thought the intention of bringing methadone clinics under the auspices of these organizations was to make methadone treatment accessible to more people in desperate need of such treatment.

Instead of streamlining the jobs of the providers, they are tied up making sure they have the paperwork in order. Instead of reducing the number of paper shufflers and increasing the number of counselors on staff, it has only made these things worse. I believe that the [policymakers'] intentions were good, but in practice, accreditation has created a whole new set of problems.

Editor's Commentary: While we are trying to keep an open mind, thus far, we have not seen indications that accreditation is improving treatment quality. The real test is whether accreditation has forced bad treatment providers to improve, but judging by patient complaints, it generally appears that this is not the case.

In regard to patient fees, policymakers acknowledged from the beginning that the cost associated with accreditation incurred by treatment providers might result in a small increase in fees. However, "small" does not necessarily mean insignificant, as many "cash pay" patients could not even afford an additional \$5 per week. Moreover, policymakers stated that the costs may force small treatment providers out of business or otherwise require them to merge with larger treatment providers. This is because accreditors charge providers a flat fee, regardless of the number of patients being served. We have contended all along that many of the problems with treatment quality, and even treatment cost, stem from lack of competition among treatment providers. The cost of accreditation stifles competition, or at best, does nothing to increase competition. Sufficient competition may not be the only solution to the problem of poor quality treatment, but it would go a long way toward addressing this issue. Methadone patients who receive poor treatment could simply switch to another provider.

Finally, as this author suggested, the federal regulations do absolutely nothing to increase treatment accessibility. Admittedly, this is a complex issue, but reducing unnecessary regulations and taking steps to end treatment provider monopolies, and thus increase provider competition would be a good start. These two actions would help to reduce the cost of treatment--one of the biggest barriers to treatment. It is incomprehensible why methadone treatment costs so much in many areas, when the medication is so cheap. We will follow this and the aforementioned issues and continue to report on the accreditation system and its impact.

Dear N.J. (from p. 2).

many of us went to some lengths to arrange extra supplies and learned how to cope without computers, electricity, running water, security, etcetera in case of the worst scenario.

It is most unfortunate that some of your clinics did not cope well with the recent power failures. In times of need, it should be possible to give stable folk increased numbers of take-home doses as happens at Christmas, Yom Kippur and other holidays. Unlike annual holidays, however, power failures, storms, petrol or transport strikes and other utility mischief may not be predictable. Patients should always receive access to the best communication possible, and extra take-homes should be used where possible to facilitate the difficult period safely.

Automatic electronic dispensers are wonderful innovations, but when they fail, all you need is a 20 ml syringe and a mixing cannula costing less than one dollar to do an entire shift at a busy dispensary. ID cards should be manual (hard copy) for unfamiliar patients or staff. There should be at least 5 days spare supply of the drug in the safe(s) on the clinic premises and arrangements for others to be available if necessary from other local suppliers.

The North American power failure of August 2003 should be a wake-up call to get real about emergency planning. The threat of terrorism should also make us think of ways to avoid mayhem in the absence of the common services we have learned to take for granted. In Australia, as in most other countries, it is not so crucial, since most pharmacies can dispense methadone, so there is more choice and more flexibility.

**Dr. Andrew Byrne, General Practitioner
New South Wales, Australia**

[See page 1, "Blackout Disrupts Methadone Treatment," for more about this topic.]

Beth Francisco, Senior Editor - (810) 250-9064

Aaron Rolnick, Managing Editor

Methadone Today (Vol. VIII, No. VII)

P.O. Box 90337

Burton, MI 48506-0337

http://www.methadonetoday.org

E-mail: bethfrancisco@netzero.net

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** \$15 yr
- DONT membership only - \$10/yr.
- Subscription to **Methadone Today with membership** - \$23 (save \$2)
- Single-copy *clinic/institution* -\$25 yr /10 issues - you may reprint up to 100/mo.
 - \$50 yr. - to 500 copies/mo. \$100 - to 1000 copies/mo. \$150 - unlimited
- Clinic subscription (\$350/yr. - 100 copies/mo. will be delivered to clinic).
- Back issues - \$10 each - Vol. I - VII (or \$35 all issues to date)
- Donation of \$ _____ to send **Methadone Today** to someone who cannot afford it or to educate policy makers, clinic staff, medical personnel, and general public.
- Enclosed are _____ 37-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, \$7 without order.

Name _____ Phone: _____

Address _____

City/State/Zip _____

E-mail: _____

For Medical Alert Card only:

Clinic Name _____ Clinic Phone: _____