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Methadone Today

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Treatment of Inmates on MMT

By Aaron Rolnick

Jails and prisons often will not provide methadone to inmates on MMT prior to incarceration, yet such jail/prison actions are rarely challenged in court. In the August 1996 issue of ***Methadone Today***, "Sad Tales From Nassau County Jail", by Donna Schoen, compiled a set of stories by several inmates of the cruelty they were forced to suffer as a result of the jail refusing to provide methadone to them or rapidly detoxing them despite being maintained on methadone prior to incarceration. Although all the stories came from the same jail in Nassau County, New York, the editor of ***Methadone Today*** made sure to point out that, "Any city, Anywhere, USA could be substituted." Unless a particular state has legislation requiring jail and/or prisons to dose inmates on methadone or even setting standards for detoxing inmates on methadone, jails and prisons with a few exceptions have a great deal of leeway in detoxing/dosing inmates on methadone.

Anyone who has suffered the debilitating symptoms of withdrawal syndrome knows that enduring the pain and suffering of it is like being tortured. Jails and prisons that withhold an inmate's dose technically are not directly inflicting pain and suffering, but withholding necessary medication makes the jail/prison as responsible for the pain and suffering as if a jail/prison employee had beaten an inmate.

Furthermore, a jail or prison withholding necessary medication resulting in severe withdrawal syndrome is just as cruel as any direct act of torture. Not even considering the possibility of relapse, depression, and even suicide, cold turkey withdrawal or even a 6-day detox from a very common dosage of 100 mg. of methadone would result in severe physical withdrawal symptoms that would probably be more painful than, for example, a flogging, a practice that would not be allowed in a U.S. jail or prison. Thus, jails and prisons should be prohibited from forcing an inmate to go through cold turkey withdrawal, detox at an untherapeutic rate, or even involuntary detox at all.

Contrary to the notion that withholding medical care from inmates is, or at least should be, considered unconstitutional "cruel and unusual punishment" pursuant to the 8th amendment to the U.S. Constitution, the courts have only recognized ***(Cont p. 3)***

Patient Story--MMT Turned My Life Around

I am a 38-year-old lady who has been a heroin addict since age 16. At 19, I was sent to prison due to shoplifting to obtain my drugs. At 27, I was on my way back to prison for the third time, receiving a twenty year sentence. I felt my life was over. I spent seven years in and was paroled in 2000. I was now a grandmother at 34 and had spent over a third of my life inside.

I was clean for a year and got sick after receiving a colonoscopy for stomach problems. I got thrombosed hemorrhoids from the colonoscopy and an emergency life or death surgery ensued. After the surgery, I was given large prescriptions of Loratab 10's & 7.5's from three different doctors I was seeing for different problems. I had never heard of Loratabs or hydrocodone. This drug became popular while I was locked up. I never thought I was addicted because I was legally obtaining my medicine from a pharmacy. I was working as a Data Entry Operator at a large university every day and taking my legal medicine. Life was okay until I started running out of my drug because it took more and more to keep me out of pain—even if it was just in my head. I couldn't make it to work until I obtained more through lying and refills. Finally I admitted that I recognized this all too familiar road. Once again, I was a low-life liar who started scheming to obtain my drug. I quit my job and moved back to my home town.

I started selling methamphetamine and doing it to ease withdrawal from no pills or trading methamphetamine for pills. I knew my lifestyle was destined to take me back to prison. But, I was already in so deep I figured out a way to escape that route when the time arrived. I decided, if I were to get arrested I would not make it to prison because I would have the police kill me. I would've rather ended up dead than go back; my life was nothing, I felt I wouldn't be missed anyway. I did drugs because I couldn't escape the hurt of a very abusive childhood, which led me to abusive relationships; reconstructed nose and broken bones were nothing compared to the broken shell of a person I had become. I thought I was doing good not being a homicidal maniac.

Ultimately I was busted. By the Grace of God I was introduced to "Drug Court" mainly because I had never ***(Cont. p. 2)***

Fight AIDS--Support Methadone Treatment

Recently, much attention has been focused on the AIDS epidemic. Events from benefit rock concerts, to news segments, to public demonstrations, have been held regarding various issues relating to AIDS. Everything from the need in Third World countries for supplies of the very expensive medications used to treat patients who are HIV positive or who have full blown AIDS, to the problem of unsafe sexual practices among teenagers and young adults. Yet not nearly enough has been said about the transmission of HIV [not to mention hepatitis C] through i.v. drug use--mostly, among i.v. heroin/opiate addicts.

The U.S. government should be embarrassed that they have done so little to reduce the spread of HIV among i.v. drug users. It is not as if we do not know how to reduce disease transmission in this manner--Australia has kept a much better handle than the U.S. on the spread of such diseases through contaminated injection equipment. One must accept however, that the majority of U.S. politicians and the general public are not ready to permit many of these "harm reduction" measures (i.e., needle exchange programs, safe injection rooms, etc.). But there is something that can be done to reduce the transmission of HIV among i.v. opiate addicts that the public would find fairly acceptable--increase the accessibility of opiate agonist treatments, like methadone maintenance. The U.S. government could make a serious dent in the rate of HIV infection by taking steps to make sure that methadone treatment is available everywhere in the U.S. and that no opiate addict is prevented from obtaining methadone treatment due to inability to pay. Note that for every dollar the public spends on methadone treatment, it saves several dollars, so the government can certainly afford to fund methadone treatment. The same goes for state governments which could make positive changes by amending state Medicaid coverage to include methadone treatment (as Medicaid only covers MMT in roughly one-half the states) and by easing state regulations of MMT in general.

Research clearly demonstrates that methadone maintenance therapy greatly reduces the transmission of diseases like Hepatitis C and HIV. The research was so compelling that Canada actually decided to provide methadone ***(Cont p. 3)***

MMT Turned My Life Around (from p. 1).

been in trouble for drugs. This was my very first drug charge. Twice a week, I had drug counseling classes, UA's twice a week for a year, NA and AA classes three times a week and a meeting with the judge once a month. I was sent to a 38-day rehab from jail, and throughout all of this, I still was relapsing every 1½ to 2 months. Sometimes I'd get caught; sometimes I wouldn't. Punishment was a sanction, to a weekend in jail or community service. I figured that eventually I was going to go to prison because I couldn't stop the relapsing. If they didn't know by now they would soon--I am an ADDICT!

I was sent to a 7-day detox center, kicking and screaming over yet another sanction. This is where I met my future husband. He is an alcoholic who voluntarily went there to get sober. I learned more from him about the Big Book (AA book) and about powerlessness than I ever did from any institution as far as addiction is concerned. All the time I remained in Drug Court, he stood by me (clean). Even when I would hide, get high, and end up having to go to jail and tell him I got a positive UA, he would tell me that in my own time I would get clean and not until; but no matter what, he did not judge me, and he has remained by me 100%.

The day came when I learned about two methadone clinics in Tulsa. My first attempt failed; she said I did not look like I was in withdrawal--no vitals taken or anything. I left there in tears. I was immediately told about the other clinic where I drove as fast as I could (tears and all). This clinic was very welcoming and professional. I did the necessary paperwork and dosed. Since that day I haven't relapsed nor have I had the desire to. A few weeks later, my husband also got on there. It has been a year and six months now. This is the longest we have both been clean.

I had to hide the fact that I was on methadone from Drug Court because they want you to abstain without the help of anything except 12 step programs, a sponsor and peer support with counseling. I tried that and still I was relapsing. . . all the while knowing I would be UA'd, knowing I would go to jail and ultimately back to prison if I kept pushing the envelope. Obviously this disease was out of control, as it has always been.

The powers that be over the Drug Courts have the mentality that methadone is a crutch--a drug replacing a drug. And they believe we get high on it like we do illicit drugs and become dependant upon it—therefore, how can this be better than abstinence? They will not listen to reason, nor believe the thousands of people who (like me) have 100% quality of life improvement--who are willing to follow the rules of Drug Court and society as long as they are on the very medicine that sustains them. If the Judge had found out I had been taking it the last year of my Drug Court term, I would have been ordered to stop, and I shudder to think where I would be at the present. There was an instance in the last three months of my DC program where a snitch, who for some unknown reason, had been taking methadone and quit. They told that there were three other individuals who were going to clinics while in Drug Court. To our surprise, an announcement was made in counseling one evening in which we were told they had been informed and they were going to add a new test to their UA screening which would detect methadone. Thank God, I graduated before they started using the test.

When I am completely off of parole, I have plans to go to my district attorney and a few judges to speak to them about the benefits of methadone. I am going to tell them how I made it through their program. I am going to advocate that they allow their clients to be afforded the treatment that I know will change their lives like it has mine as well as so many others. When I first entered the Drug Court program, I was told that the counselors who ran it had the mentality that the clients who were pill heads or opiate addicts were usually written off at some point in time due to the fact that very few of us successfully completed this program. They believe our addiction is much harder to overcome and that statistically we're the ones who end up being sent prison for failing the program. I have to say that they were very lenient with me, more times than I thought they would be. But, I also know that had I not found methadone, I would have been a statistic, on the run, or dead.

My life is better than I have ever known it to be and always wished it could be. It's been a long time coming and I know I owe it all to and thank my God, my husband and the methadone treatment program.

Naloxone Treatment is Ineffective

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

**The Effectiveness of Combined Naloxone/Lofexidine in Opiate Detoxification: Results from a Double-blind Randomized and Placebo-controlled Trial. Beswick T, Best D, Bearn J, Gossop M, Rees S, Strang J. American Journal of Addiction (2003) 12;4:295-305.*

This intriguing trial from a London based group gave frequent injections of naloxone to addicts in a detoxification ward.

The authors state that methadone 'has been the standard treatment for inpatient opioid detoxification'. This may be the case in England but not necessarily elsewhere. There seems to be an assumption that lofexidine (and/or clonidine) are safe and effective in outcomes of opioid withdrawal episodes. Although there are apparently fewer hypotensive side effects with lofexidine ('Brit-Lofex), a recent study from England, a generation of experience and the absence of a reported black market would seem to cast some doubt on their efficacy in successful heroin withdrawals. Next comes the rather controversial and little-researched use of naloxone in drug withdrawal. These researchers gave most subjects over 30 hypodermic injections, a behaviour which most of us are actively trying to discourage.

After finding that there were no significant differences in overall outcomes in those randomised to receive the antagonist naloxone, the authors come to the surprising conclusion that more research is needed on this treatment modality for those trying to quit heroin. With the increasing use of buprenorphine for detoxification, it would seem almost outlandish to support the use of injectable, short-acting antagonists like naloxone.

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 Chicago;
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.

Inmates on MMT (from p. 1).

a limited right of an inmate to medical care. The courts have used two different standards to determine the rights of inmates: one standard for "pretrial detainees" (those held in jail or prison awaiting trial) and another less stringent standard for those already convicted and serving time.

The U.S. Supreme Court addressed the rights of convicts to medical care in ***Estelle v Gamble*** (1976). In *Estelle*, the Court ruled that failing to provide a convict with medical care only violates the 8th amendment if: 1. The denial or delay of medical care is deliberate. 2. The medical needs that are not tended to are serious (will result in sufficient harm to the convict). Unfortunately, these standards are very stringent and quite difficult to prove. Obviously, most jails and prisons are going to do just enough to demonstrate that any inadequacy in a prisoner's medical care will not be found to be "deliberate"; in Estelle, the Court explains that, "an inadvertent failure to provide adequate medical care" would not violate the 8th amendment (if it's not "deliberate," then it must be "inadvertent" and permissible). Thus, even medical malpractice would be allowable, as long as the inadequacies were not intentional.

Given the above standard for determining whether denial of medical care constitutes a violation of the 8th amendment, the likelihood of a jail or prison withholding methadone from a convict being ruled unconstitutional is very low. As long as the inmate is examined by a doctor at some point, the jail or prison is probably under no obligation to provide methadone, and at very most, may be required to provide minimal medication to ease withdrawal symptoms.

The degree/standard of medical care that jails and prisons are constitutionally required to provide pretrial detainees has not been clearly established by court decisions. Unless a court case has already established that a medical treatment (or lack thereof) is cruel and unusual punishment, the court must decide whether the treatment/denial of treatment should be considered a punishment.

In ***Allegheny County Jail v Pierce*** (1979), the Court declared that absent an expressed intent to punish, if a restriction of pretrial detention is reasonably related to insuring jail security or making sure the prisoner attends trial, it is not unconstitutional "punishment". On the other hand, if the restriction of pretrial detention is "arbitrary or purposeless," then the action is considered unconstitutional punishment and may not be inflicted upon the prisoner.

The Federal Courts have made different and sometimes conflicting determinations of whether, or under what circumstances, jails and prisons may rapidly detox or simply refuse to dose a pretrial detainee who was on methadone maintenance before being incarcerated.

In ***Cudnik v Kreiger***, the District Court determined that jails and prisons do not have a legitimate reason to withhold methadone from methadone maintenance patients and therefore, it is unconstitutional for them to detox a pretrial detainee at all.

In ***Norris v Frame***, the Court of Appeals reasoned that there could be a legitimate reason to withhold/limit methadone, but whether there is depends on the circumstances. If a jail or prison had dosed inmates in the past, the Court doubted that the jail or prison all of a sudden needed to withhold methadone for security or other legitimate reasons. On the other hand, many courts have ruled that jails and prisons have a legitimate security interest (albeit weak) in withholding methadone from pretrial detainees and have allowed detox or even a complete withholding of methadone, at least if tranquilizers and/or other medications are used to somewhat ease withdrawal: ***Allegheny County Jail v Pierce, Owens-El v Robinson.***

The courts have virtually eliminated the rights of convicts and have limited the rights of pretrial detainees who are methadone patients to maintain on methadone. The preponderance of Federal Appeals Court decisions have permitted jails and prisons (at least under certain circumstances) at a minimum to limit a pretrial detainee's access to a short (6-day) detox. Fortunately, the courts have not yet set this in stone, and since the U.S. Supreme Court has not ruled on this issue, **pretrial detainees may still be able to obtain a fair hearing**. Thus, if a medical expert could convince the court that given the relapse rate and severity of physical withdrawal symptoms that a jail or prison forcing a detainee to detox is not reasonable, it would indeed constitute punishment.

One Final Note:

The US Supreme Court has not taken any such methadone cases, so until/unless they do, the lower federal courts are left to determine whether jails/prisons are allowed to withhold methadone from pretrial detainees. In the US Sixth Circuit, which includes Michigan, no such methadone case has reached the Court of Appeals. The only such case within the Sixth Circuit reached a US District Court in Ohio: ***Cudnik v Kreiger***.

A District Court is inferior to a Court of Appeals and therefore not binding on a Court of Appeals. However, the courts generally prefer to remain consistent with other courts and court decisions within their circuit. Therefore, other district courts within the Sixth Circuit, as well as the Sixth Circuit Court of Appeals, may be persuaded to follow the decision of the Court in *Cudnik v Kreiger*. Fortunately, in that case, the Court ruled in favor of the pretrial detainee, agreeing with them that jail/prison security is not advanced by withholding methadone from inmates and, therefore, was punishment and in violation of the detainee's constitutional rights. Thus, pretrial detainees in Michigan and the Sixth Circuit may be able to successfully sue to obtain methadone maintenance by persuading the courts to follow *Cudnik v Kreiger*.

Note: Thanks so much to Aaron for taking on this complicated assessment.

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Fight AIDS (from p. 1).

maintenance treatment to opiate addicted inmates to reduce the transmission of Hepatitis C INSIDE the prison. Thus, if politicians really care about stopping the spread of HIV, they will educate themselves about opiate agonist treatment and support methadone maintenance treatment. Those who continue to bash methadone treatment are obviously more interested in scoring political points by attacking a treatment that the public generally dislikes than in slowing the spread of AIDS.

Rush Limbaugh's addiction places media spotlight on opiate addiction

Conservative political commentator, Rush Limbaugh, recently admitted publicly that he is addicted to prescription opiates. He indicated that he has been addicted to opiates for quite a while and had unsuccessfully attempted to quit numerous times. This has apparently been an ongoing issue for him, as he has hearing loss--which doctors believe is at least partially attributable to his abuse of Vicodin. Vicodin, but not other pain medications, has been associated with hearing loss when abused on a long-term basis.

Public figures admitting their addiction to opiates or other drugs is hardly new, but Limbaugh does not fit the stereotype—drug addicted rock stars—that certainly appear to the general public as hedonistic. In fact, one might suggest that Limbaugh is the complete opposite as the stereotypical drug addicted rock star. And Limbaugh would be the first to condemn the "hedonistic rock lifestyle" as immoral. Thus, Rush Limbaugh's admission represents an opportunity to educate and raise awareness about opiate addiction and opiate agonist treatment.

Hopefully, this will illustrate to people that opiate addiction affects people from all walks of life. People may also come to realize that a significant proportion of opiate addicts become addicted while taking opiate pain medication for a legitimate medical purpose. In Rush Limbaugh's case, he was prescribed Vicodin for back pain. In fact, doctors are generally doing a better job of adequately treating pain in their patients; while this is definitely a positive, somewhat more patients may become addicted to opiate pain medications than in the past.

However, advocates and media watchdogs will need to monitor the content of media reports and complain if there are inaccuracies or if the journalists miss the real story. One of the concerns is that the media will focus the story on the drugs themselves and how "bad" they are, rather than the issue of opiate addiction--treatment for and attitudes regarding. Obviously opiates do have a potential for harm, but there are medical circumstances where the benefits [pain relief] outweigh this potential for harm. Using the story to condemn certain pain medications carries a danger in itself--that doctors will be pressured to prescribe less of these pain medications, as underprescribing is already a problem due to harassment by the DEA of doctors that prescribe certain medications, not to mention the fact that some doctors are still misinformed regarding pain medications and the benefits of providing adequate pain relief. Reporters often neglect to mention that only a small percentage of patients prescribed opiate pain medications, even on a long-term basis, actually become addicted to the medication or that adequate pain relief makes a big difference in how rapidly the patient recovers from surgery, disease, etc. At minimum, if news stories spend too much time on the drugs themselves, they will have no space to devote to opiate addiction (i.e., that opiate addiction occurs among people of all classes, backgrounds, ethnic groups, religious beliefs, etc.) and opiate addiction treatment (that opiate addiction is a medical condition that requires a medical treatment--not a lifestyle choice or a moral deficiency, and that it is likely caused by a chemical imbalance in the brain, which may be corrected* by opiate agonist treatment).

Whatever we think of Rush Limbaugh's political opinions, we should do everything to avoid squandering this opportunity to educate the public about opiate addiction. Instead of the public viewing opiate addiction as being a problem that only affects certain kinds of people, maybe they will see that opiate addiction can affect anyone--even you, a friend, or a relative. Perhaps then the public will look more favorably on effective opiate addiction treatments like methadone maintenance and question the spending of public funds on incarceration of addicts rather than treatment. How many people would agree with throwing Rush Limbaugh in prison essentially for being an opiate addict?

**In this context, "corrected" should not be confused with "cured". Opiate agonist therapy can successfully treat the chemical imbalance but, like insulin, only corrects the chemical imbalance as long as the patient takes the medication. This explains why methadone maintenance treatment is associated with a very high success rate, while the relapse rate is high among those who have tapered [AKA, "detoxed"] off of methadone [or buprenorphine].*

Editor's Note: Though we guess that Rush Limbaugh will never have to serve serious prison time, he is being investigated for alleged criminal activities related to his addiction to pain medication. Either way, maybe it will force more policymakers to question whether the U.S. has taken the correct approach--incarcerating, rather than making treatment available to, drug offenders.

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