Methadone Today

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An Interview With Dr. Vincent Dole - (Part II)

by Odus Green

This is the second of a two-part interview with Dr. Vincent Dole, Father of Methadone Maintenance. This material was gleaned from two separate conversations we had over a two day period in January. Dr. Dole is without doubt one of the most humble, self-effacing men I have ever had the pleasure of meeting. I can only hope this interview can convey the intelligence and dedication of this man. To this day, he is still very much involved with Methadone and its application toward freeing drug addicts from their dilemma. That dilemma being the black market which the government keeps strong and viable simply by keeping drugs illegal and treatment all but unobtainable. The fact is, even if one is able to get into a treatment program, the rules which govern dispensing methadone are archaic and very constraining in their application. Hopefully, one day methadone will be available through private physicians. Only then will many people be able to lead full, normal lives. As it stands now, we will continue to be "punished" as long as we remain in treatment.

Odus: How do you see "for-profit" clinics affecting Methadone treatment today?

Dr. Dole: I believe there is too much prejudice against "for-profit" clinics. While there is some foundation for prejudice against them, you must remember that any hospital or medical clinic is in business to make a profit. Now, to open a Methadone clinic strictly because you see a profit is doing nothing more than handing out medicine; that is obviously wrong and motivated by greed. Still, if you look at the history of practicing medicine, doctors have always had to make enough money to eat. I do not see making a profit as a bad thing, and I think it can be good, particularly if it breeds competition. You see, if money is being made, then others will want to enter the field, and this keeps any one person from having a monopoly, thus charging whatever he wants. Competition will ultimately keep the prices down to an affordable level. However, I do not at all like the idea of exploiting people to make money.

Odus: How do you feel about the licensing procedure for Methadone clinics?

Dr. Dole: Well, I do believe it helps keep out many doctors who would otherwise not be the best choice for the position. However, it also tends to facilitate the hiring of people with little scientific knowledge and they don't really care either. Some of the people who are lower on the scale tend to see themselves as simply "filling a slot" and only there to fulfill the rules. This is not the best environment in which to carry on treatment. In some states, the system is set up so that it is purely political in nature, and that is definitely detrimental to Methadone treatment. These politically based clinics are typically some of the worst around.

Odus: How do you see private physicians fitting into the scheme of things in the future?

Dr. Dole: I feel that this will go a long way toward addressing the size problem we are faced with now. Many clinics have way too many patients on their programs. There is no way one physician can handle 500 or 600 patients. Also, this translates into counselors having 50 or 60 patients. You can't assure proper treatment when it takes all your time simply to fill out paper work. With all the paperwork required, there is simply no time for counseling, and this is a sad situation.

Odus: Have you read the "Swiss Heroin Report" and if so, what did you think about that?

Dr. Dole: Well, yes, I did read it. The question, "What did I think" reminds me of the old question "How's your wife?" and the obvious answer is, "Compared to what?" My feeling is, the attitude with which the Swiss approached this is a pragmatic one. They left behind the presumptions and simply said, "Let's just see what we can do to help," and that in itself is a good thing. I feel that this alone makes it much more successful than a repressive study. Unfortunately, it is posed here in such a way as to say "Which drug is more successful, this drug or that drug?" My own experience is that heroin is not an ideal drug for maintenance simply because its period of action is just too short. Also, injection is not the ideal way to give a medicine which will be taken frequently. ***(Cont. p. 3)***

Story on Methadone Abuse Misled Viewers

Recently, a local television news program (WDIV, Channel 4 [Detroit-NBC]) ran a segment on abuse of methadone--particularly focusing on teenagers. The segment did not discuss how the methadone was being obtained or where it came from, except to state that methadone was dispensed for the treatment of opiate addiction AND to treat pain. The problem is that many viewers are going to assume that most of the abused methadone came from opiate addicts in methadone treatment, even though the segment never indicated where the majority of "diverted" methadone came from.

In fact, research into the recent increase in methadone diversion and abuse has found that the diverted methadone is mainly coming from patients prescribed methadone for pain, and NOT from methadone clinics/opiate addicts in methadone treatment--this was the conclusion of a SAMHSA (Substance Abuse and Mental Health Services Administration) report released in February of this year (SAMHSA is a federal government agency). How can researchers tell? With rare exception, methadone clinics dispense methadone in liquid form--from methadone formulated as a liquid, or from methadone wafers or "diskettes" which are dissolved in water or juice prior to dispensing. Conversely, methadone prescribed for pain is usually dispensed in pill/tablet form. So by looking at the methadone, it can be determined with relative certainty whether it came from a methadone clinic or not. With the public's negative perception of methadone treatment in mind, the news could have avoided misleading viewers by indicating that the methadone mainly being abused did NOT come from methadone clinics.

While much of what the news said is true, their sensational coverage misrepresented the extent of methadone "abuse"--especially when it comes to minors. Indeed, in recent years, the diversion--and consequently, abuse of opioids has significantly increased. The main reason for this trend is that physicians are prescribing more opioids for the treatment of pain; as physicians have become more aware of the importance of adequately treating pain, they have changed their prescribing practices. ***(Cont p. 3)***

Buprenorphine and Safety During Pregnancy

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

[A recent] Addiction edition *(Addiction [2003] 98*) has some largely reassuring information on buprenorphine in pregnancy with 13 cases reported from France. The authors [Kayemba-Kay's S et. al.] state that no teratogenic effects have been reported and that their cases had variable neonatal abstinence syndrome but of shorter duration than with methadone. Two cases (15%) had some motor abnormalities which did not resolve completely at follow-up.

Editor's Note: Currently, methadone treatment is the only recommended opiate agonist treatment for pregnant women. Female LAAM patients of child bearing age have always been required to take monthly pregnancy tests, and LAAM or buprenorphine patients are advised to transfer to methadone during pregnancy.

In the case of buprenorphine, switching to methadone during pregnancy can be a hassle, as the regulations [particularly in some states] governing methadone treatment are stricter than those governing buprenorphine treatment. Pregnant buprenorphine patients who are used to getting treatment through their doctor's office once a month, suddenly have to attend a methadone clinic at least once a week. Moreover, once the pregnant patient has given birth, transferring back to buprenorphine is sometimes problematic (i.e., the patient will have to taper her dose to 30 mg/d or lower before switching back to buprenorphine).

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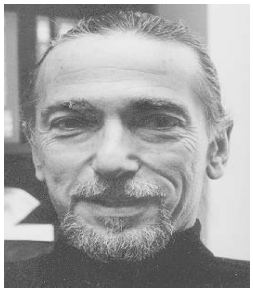

Column From the Doctor

Dependence vs. Addiction

PHYSICAL DEPENDENCE DOES NOT CAUSE ADDICTION. ABSTINENCE DOES NOT CURE ADDICTION. NALTREXONE IMPLANTS AND DEPOT FORMULATIONS MAY NOT BE THE BEST WAY TO GO.

Many believe that addiction and physical dependence are the same thing. They are two very different issues. This has been demonstrated repeatedly in animal and human studies. Physical dependence may be a side effect from substance use, licit or illicit, taken for medical or recreational self-medication purposes. It RARELY leads to addiction, which has to do with obsessive pursuit and abuse in the face of self-destructive consequences.

Neither many patients made physically dependent in the course of medical treatment nor lab animals that we make physically dependent in experiments, who do not have the "right stuff " (genetics or high stress environment), ultimately behave as addicts.

Physical dependence can be medically managed fairly easily and inexpensively, if done so slowly, by most experts on an outpatient basis. Hospital treatment is usually not necessary. In addiction, it is usually not very effective for long.

NALTREXONE, Alcohol and Opiate abuse

Blocking development of physical dependence or some other responses that depend on stimulation of opiate (opioid) receptors in the brain with naltrexone is an attractive idea to many people. While it is common sense, addiction isn't that simple.

Naltrexone is a useful tool in the treatment of alcohol abuse. It might be useful in the treatment of some heroin addicts. It must be used in ways which protect patients from overdose and creation of high levels of drug craving, depression and diminished sexual interest, in my (research informed) opinion. Chronic administration may not be the way to accomplish all these goals.

Administration of naltrexone on a daily basis for long periods, as is now possible through implants, depot injection or direct observation of oral dosing, will prevent physical dependence on opiates and many of the effects of alcohol that result in abuse. Used in this manner, it leads to increased craving and increased reaction to alcohol or opiates when the blockade is stopped. This means that a little will go a very long way, leading to disinhibited behavior, blackout in the case of alcoholism, or death in the case of heroin, on very low doses of drug once naltrexone blockade is removed. Long-term daily (or depot) use of naltrexone in alcohol treatment is inferior in these respects compared to its intermittent use, and I am wondering whether this might be the case in regard to the treatment of heroin addiction. The short-term results might be better for chronic uninterrupted blockade, but the long-term results may prove otherwise. It is something to watch. Frankly, I hope that I am wrong about this. If this chronic endorphin blockade does turn out to be a good intervention after all, using the depot injection recently available somewhere (Naltrem) would be a simple procedure.

Dr. Marc Shinderman
Center for Addictive Problems (CAP)

Interview With Dr. Dole (from p. 1).

Odus: What do you think about drug prohibition altogether?

Dr. Dole: Now, that is an open-ended question. By that I mean, you can't just give a "yes" or "no" answer to it. Certainly, prohibition as we've seen it has been unproductive. It has had the opposite effect from its intentions. The question is, "What can we do to ensure the rational use of dangerous drugs?" The forces of prejudice, ignorance, and demand are such that it cannot be "solved" by policy or law. Taken in context of time, it is obvious that these drugs have been used since their discovery and will continue to be used in the future by some people. What to do about that, I don't have the answer. There is no policy which can change anything overnight, which is what politicians will try to do. Actually, political expediency is sometimes hostile to common sense. All we can do is try to change the trend in which the country is heading.

Odus: From my reading, I understand you had many detractors during your years of research. Who were they, and why were they against your work?

Dr. Dole: Oh yes, there were many who didn't like what I was saying, especially the "Federal Bureau of Narcotics and Dangerous Drugs" (BNDD--this is the forerunner to today's DEA). They tried every way possible to discredit me. Luckily, I was sufficiently entrenched in the University system that they couldn't do anything. Their power was too weak to reach me there. Now, Dr. Nyswander actually did risk imprisonment in her work. She was simply a private practice doctor who risked her freedom many times to help addicted persons. In that position, she didn't have the protection I did being a University researcher. I will say there was a lot of drama between myself and Mr. Anslinger (Mr. Anslinger was the head of BNDD).

Odus: Anything you'd like to add for folks to know?

Dr. Dole: Just that you people who are involved in advocacy, keep up the work. I have seen changes come about because of people becoming involved. It is these who are the real heroes in all this. Without advocacy, changes will not come about within the present system.

This ends the interview. *Again, I'd like to Thank Beth, Editor of* ***Methadone Today****, for making this possible. I hope everyone will take Dr. Dole's advice and become involved in advocacy at your own clinic. Even the little things will add up to a total advocacy movement. Let's not take the word of anyone and assume "****It's in the regs.****" If you follow up on many of the more outrageous rules you encounter, you will find that the worst rules are instituted at the clinic level, not the federal or state level.*

The clinic is the easiest place to change these rules. All it takes is a bit of dedication and hard work. Together, we can change things folks. Some day, I want to be going to my own physician for my medicine, as I should have been doing for years now. Thanks to all. - Odus

Editor's Note: As this interview was conducted before the adoption of the new federal regulations, some of its contents are dated----in particular, about licensing procedures. Though the current federal regulations require treatment providers be "accredited", rather than "licensed", most of Dr. Dole's criticisms of the system still apply.

Story on Methadone Abuse (from p. 1).

Physicians are doing the right thing, but people need to understand that as more pain medication is prescribed, unfortunately, more such medication will also be diverted and abused; however, most patients do not divert their medication.

It would have been more accurate had the news aired a segment on the abuse of prescription opioids generally--but they know that a story about "methadone" will grab more viewers than a story about pain medication. Even cursory research reveals that methadone is far from the top of the list of abused prescription opioids. Even their news story noted that methadone does not give the intense high associated with many opiates, perhaps explaining why methadone is not one of the more popular opioids of abuse; short-acting opiates like oxycodone (Oxycontin) or hydrocodone (Vicodin) are far more commonly abused.

WDIV local news could have done a much more thorough and accurate job of reporting on the problem of prescription opioid abuse had they avoided sensationally singling out methadone for their story. At minimum, they should think about the potential negative consequences of their story (i.e., increase in the negative stigma against methadone patients), and avoid misleading viewers (i.e., leading viewers to believe that most of the methadone being abused came from methadone clinics when it mainly came from patients prescribed methadone for pain).

Unconstitutional? (from p. 4).

opiate addiction by the methadone clinic physician.

Thus, Boucher goes further than merely stating that withholding methadone completely [while, at most, providing insufficient medications like Tylenol, to ease some of the withdrawal symptoms] violates inmates' Eighth Amendment constitutional rights; she argues that inmates who were on MMT prior to incarceration have a constitutional right to be maintained on methadone for the duration of incarceration, or until/unless the inmate and his/her methadone clinic physician determine that a methadone taper is appropriate. In making this argument, Boucher boldly focuses on the long-term consequences of terminating methadone maintenance treatment--even for a relatively short period of time. In the aforementioned ***Methadone Today*** article, Aaron Rolnick argues that the pain of abrupt (e.g., "cold turkey") withdrawal from methadone is equivalent to torture, and therefore, constitutes "Cruel and unusual punishment"--thus, violating the inmate's constitutional rights. But Boucher is going a step further in arguing that termination of MMT violates inmates' constitutional rights even if inmates are withdrawn from methadone in a way that minimizes the pain and discomfort of methadone withdrawal (e.g., a long-term methadone taper).

Editor's Note: Rebecca Boucher used two Vermont cases from 2001 as the basis for her article. In the first case, the VDOC (Vermont Department of Corrections) was ordered to dose the inmate, but they elected to release the inmate early rather than comply with the court order. The disparity between Boucher's conclusions and that of Aaron Rolnick's in, "Treatment of Inmates on MMT" may be due in part to the fact that the latter was originally written in 1998--prior to the aforementioned Vermont cases.

Even in the short period of time (five years) between when "Treatment of Inmates on MMT" was written and when Rebecca Boucher wrote, "The Case for Methadone Maintenance Treatment in Prisons," the medical community has somewhat changed its position towards opiate addiction and MMT. Since 1998, professional medical organizations (i.e., the American Medical Association) have more actively endorsed MMT as the preferred treatment for opiate addiction and called for regulatory changes to make MMT more accessible to those who need it. These factors may partially explain why Boucher drew different conclusions than Rolnick.

Is Refusal to Provide Methadone to Inmates Unconstitutional?

Rebecca Boucher, **The Case for Methadone Maintenance Treatment in Prisons, 27 (No. 2) Vermont Law Review 453-482 (Winter 2003).*

In the December 2003 Issue of ***Methadone Today***, we printed an article, "Treatment of Inmates on MMT," in which author Aaron Rolnick (a paralegal who is also the Managing Editor of ***Methadone Today***) analyzed the constitutionality of prisons/jails withholding methadone from inmates who were on MMT prior to incarceration. The article distinguished the constitutional rights of "pretrial detainees" (inmates being held pending trial, who therefore have not yet been convicted) from the rights of convicts (inmates who have been convicted of a crime and are serving a sentence). Most of the article was devoted to the rights of pretrial detainees, and the author was quite pessimistic about the prospects of successfully persuading the courts that a prison/jail withholding methadone from convicts who were on MMT prior to incarceration is violating their constitutional right to be free from "Cruel and unusual punishment." As explained in the article, pretrial detainees have greater constitutional protections than their convict counterparts and would therefore be more likely than convict inmates to persuade the courts that the prison/jail withholding methadone from them violated their constitutional rights.

However, in the Winter 2003 issue of the Vermont Law Review, Rebecca Boucher comes to a different conclusion*. Boucher argues that prisons that withhold methadone from inmates who were on methadone maintenance treatment prior to incarceration are violating the inmates' constitutional rights--specifically, their rights under the Eighth Amendment of the U.S. Constitution to be protected from "Cruel and unusual punishment." Although there were some such court cases decided in the 1970s--most of which the court did NOT decide in the inmates' favor, she believes that scientific findings regarding opiate addiction and methadone maintenance treatment made within the last 20 years or so significantly bolster the case that inmates who were on methadone maintenance prior to incarceration have a constitutional right to receive their maintenance dose of methadone during their incarceration. In the early 1970s, methadone maintenance treatment was fairly new, and there was far from a consensus in the medical community that methadone maintenance treatment is the best or most effective treatment for opiate addiction--or even that methadone maintenance is a good treatment. In contrast, MMT is now recognized by the medical community as the most effective opiate addiction treatment and the "gold standard" by which other treatments should be measured.

In regard to medical care to inmates and the Eighth Amendment, the courts follow a two-pronged test devised by the U.S. Supreme Court in Estelle v Gamble (1976). In Estelle, the Supreme Court indicated that "deliberate indifference to serious medical needs" by a prison or jail is unconstitutional. So to prevail in court, an inmate has to first convince the court that the medical need that the prison or jail failed to adequately treat was "serious". Then, the inmate has to show that the prison or jail exercised "deliberate indifference" to the medical need of the inmate. It is the second "deliberate indifference" portion of the test that has been difficult to prove. Anyway, if the medical need was not "serious", the inmate probably wouldn't have pursued it in court to begin with—though, admittedly, some inmates would enjoy occupying prison officials and the courts with frivolous law suits. The courts themselves haven't been able to entirely agree on what "deliberate indifference" is or how plaintiffs are to prove that the prison or jail exercised deliberate indifference. Just because the medical care provided would be considered medical "malpractice" does not mean that the prison or jail necessarily exercised deliberate indifference. The fact that the conduct has to be "deliberate" makes proving "deliberate indifference" especially difficult.

Boucher effectively argues that withholding methadone from inmates does indeed constitute "deliberate indifference", because: 1) It is known that the consequences of relapse to active opiate addiction are very serious and may include death or contraction of HIV (the AIDS virus) and hepatitis C; and 2) As demonstrated by various research studies, the prospects of an opiate addict remaining abstinent of opiates without being on opiate agonist treatment (i.e., MMT, buprenorphine maintenance treatment [BMT], or LAAM maintenance treatment [LMT]) are quite poor, and worse, "[f]or those whose treatment is halted against their will [as in the case of inmates withheld their methadone dose], it is a safe assumption that their chances of achieving and maintaining abstinence are even more slim." Boucher explains that, "[t]o prove deliberate indifference one must demonstrate to the fact finder that an official knew of and disregarded an excessive risk to inmate health or safety." Clearly, prisons and jails which withhold methadone from inmates who were on MMT prior to incarceration are disregarding "an excessive risk to inmate health," as the risks to an inmate's health of not properly treating their opiate addiction are substantial--and clearly, in such cases, one may assume that prison/jail officials were aware of the health issue, as the inmates in question have already been diagnosed with ***(Cont p. 3)***

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