THIS ISSUE: High Staff Turnover / A Look at Medical Maintenance / Americans with Disabilities Act

Methadone Today

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Medical Maintenance
A Future with Dignity for MMT Patients

by R. Belser

June 26, 2004, was my 27th anniversary as a Methadone Maintenance Treatment (MMT) patient. Like almost all MMT patients, I spent those years in one or another MMTP Methadone Maintenance Treatment Program (MMTP)—"the clinic." And I think most of us can agree that apart from the relatively few genuinely good and caring clinics, MMT patients have to deal with programs which combine the worst features of parole, kindergarten and so-called "mental health" counseling--knowing all the while that this regimen will go on forever, with no hope of ever being treated with the respect patients receiving other medicines expect as a matter of course. Until recently, even at "good" clinics, all that patients with years of proven track records of stability and compliance could look forward to—at best—was a once-per-week take-home schedule.

Worst of all, with a change in administration, a "good" clinic can still change almost literally overnight into the Clinic from Hell. Clinic patients have good reason to know that however bad their clinic may be, it can *always* get worse! The contemptuous treatment we receive at so many clinics, coupled with the sense of helplessness at having so little control over such a vitally important factor as the medicine which enables us to function, places enormous stress on MMT patients. One of the best pieces of evidence for how effective MMT really is has to be the stable and productive lives so many methadone patients lead, despite having to constantly contend with the degrading, unpredictable and often hostile clinic system.

During my years as an MMT patient, working to get even the most minimal positive changes, often with only small or temporary improvements at "the clinic," it was very hard not to get discouraged. As I grew older, I began to imagine myself as a feeble 80-year-old, struggling along with my walker, trying to get to the clinic before dosing hours ended—still very much under the clinic's thumb. I had begun to despair of seeing any real change come to MMT in the U.S. in my lifetime. But thanks to the efforts of many patient advocates and those in the federal regulatory system who genuinely cared about how MMT patients were treated, ***(Cont p. 4)***

Employment Drug Testing:
Know your Rights

by Aaron Rolnick

Addiction Treatment Forum, "Patients Battling Stigma & Prejudice," (Vol. VIII, #4, p. 1) reported on a research study by Nancy Nieuman, MA, CPC, which found that "more than 66% (two-thirds) reported denial of employment or loss of existing jobs due to methadone-positive urine tests." This is a high percentage, especially considering that such employment discrimination is a blatant violation of the Americans with Disabilities Act (ADA).

Given that this is such a common problem, methadone patients need to educate themselves about their legal rights and how to protect those rights. The research study cited above found that most patients were indeed not aware that discrimination based on methadone-positive urine test results, if caused by prescribed methadone, was illegal. Methadone clinics could play a role in such education by arming their counselors with handouts and information on the ADA to be passed out to patients. This is the first step as, obviously, patients will not take action if they do not know that the employer violated the law or what to do about it.

The next issue is what methadone patients should do to protect themselves if undergoing an employment drug test. Ideally, the patient should find out whether the test will include methadone. Taking methadone will not cause an opiate-positive test result. To be detected, methadone must be tested for specifically. It is often not tested for, and there is no sense in revealing that one is on methadone if it is not necessary to do so. Sometimes employers or the clinic conducting the drug test will present the employee with a list of the substances for which they are testing. But obviously, finding out whether methadone is going to be tested for is often not possible.

If you discover that methadone is going to be tested for or you are not sure. If at some point you are asked by your employer or the clinic conducting the drug test to provide a list of prescription medications, do not fail to list methadone in the hope that everything will work itself out. If they do test for methadone, you will most likely test positive for it unless you are on ***(Cont. p. 3)***

Dear Methadone Today,

I would like to introduce myself: My name is Joey, I am 38 years old, and have been addicted to opiates for about 15 years. I started taking pain medication for an injury I suffered in the United States Marine Corps. I severed the ulma nerve on my right hand and then developed a neuroma in the palm of my hand. Needless to say, I was in severe pain all the time.

I started taking Darvocet N-100, then Percocet and, finally, Dilaudid. After about eight months of medicating myself with these powerful painkillers, I was severely addicted. Once the doctor learned about my abuse of the pills, he cut me off. That was when I had to hit the streets to try and find these medications.

After a couple of years of this, I lost my wife, my kids, my home, my car . . . everything that was dear to me was gone. After this, I moved out of state with my parents. But shortly after the move, I had to be admitted to the hospital for severe withdrawal—it was then and there that my parents knew I needed professional help.

I checked into a rehab and stayed the full 30 days, but once I left, I went right back to using. After three attempts in a rehab, I was still severely addicted to opiates. I started using Oxycontin and heroin on a daily basis, but I also tried to hide this from my parents.

Then I heard about methadone. At first I really didn't know what to think as in my eyes, I was too far gone. My father took me to enroll in the program, and after a year of being on the long waiting list, I got the call and received my first dose of methadone. From that day forward, I have had a new lease on life. I've been on the program for one year and four months, and I'm very proud to say that while on the program, I have not had one positive urine—NOT ONE. My parents will say without a doubt that methadone saved their son's life. I now get six take-home doses per week, attending the clinic just once a week.

So for anyone thinking of getting on methadone because of an addiction, please try the program--it worked for me and I'm sure it can work for you. **- Joey P.** ***(Cont. p. 3)***

Study: High staff turnover, other problems plague U.S. addiction treatment industry

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

**McLennan AT, Carise D, Kleber HD. Can the national addiction treatment infrastructure support the public's demand for quality care? Journal of Substance Abuse Treatment (2003) 25:117-121.*

This 'commentary' teaches us some very important lessons regarding staffing, education and career development in the dependency field. Arising out of an unrelated study, the authors had the opportunity to interview key staff in 175 assorted American dependency treatment agencies. Ten percent were traditional methadone clinics.

The most dramatic finding, almost invalidating the other information being sought, was that within the treatment services examined, staff turnover was extremely high (up to 53% annually). Also, medical and nursing services were under represented with part-time and even volunteer workers in senior positions in many centres. Thus, we should be concerned about continuity and consistency of treatment, keeping highly trained and experienced staff in the field and allowing career pathways which can be both rewarding and sustainable. Remarkably, 15% of the agencies identified for the study had either closed down or else ceased to provide addiction services at all! A further 29% had been reorganised under different management, showing yet more starkly how much volatility there is in addiction treatment services.

Drs. Kleber and McLennan are highly respected veterans of the dependency research field. What they say in their discussion is both telling and embarrassing for an embattled and threatened rehabilitation 'industry' in their country. They found that much time was wasted in these agencies having to collect data required for insurance, city, state and federal requirements. Little if any of this information was used in any way clinically, and it took between two and four hours of staff time to collect. Few agencies used computers. The final comment of these authors goes so far as to compare addiction treatment agencies with the degraded electrical grid which was blamed for the massive recent outages in North America.

I have tried to compare these results with agencies in New South Wales and believe that things are not as grim here, but there are warning signs. I found similar staffing data in some clinics while in others, there were managers and senior staff who had been in the field for decades, providing excellent care for dependent patients/clients.

High Staff Turnover: Steps must be taken to remedy this serious problem

It is already well known that treatment accessibility is a major issue in the U.S., where drug addiction treatment is only available to a fraction of those who need it. This study (*see Dr. Andrew Byrne's article at the top of the page, for information) suggests that a large portion of treatment providers are not providing quality treatment. Even assuming staff are well-qualified, high turnover is likely to compromise their ability to provide quality treatment to patients.

In methadone clinics specifically, as well as addiction treatment providers generally, high turnover is the most problematic among counselors. To be effective, a counselor really needs to develop a rapport with the patient. There is an argument to be made that developing trust and rapport is even more important in the methadone clinic setting than in other outpatient settings; methadone clinic doctors often take input and advice from counselors concerning dosage and other issues and may defer to counselors entirely regarding take-homes (i.e., whether take-home privileges should be increased or rescinded). Methadone clinic counselors have power over various aspects of treatment that substance abuse counselors in other settings do not; therefore patients may be unwilling to share personal information with a counselor they do not know well.

Additional research into why staff turnover is so high is in order. It is likely that some of the causes of high turnover are also negatively affecting treatment quality in other ways (i.e., counselors may be quitting because their caseloads are too high, but excessive caseloads also compromise treatment quality when counselors do not have enough time to devote to individual patients). Clearly, high staff turnover jeopardizes treatment quality and must be addressed.

Policy makers and proponents of the present accreditation-based system** claimed that accreditation would improve treatment quality. Here is an opportunity to demonstrate that accreditation will really do that. One of the many impediments to quality treatment has been identified and outlined (high staff turnover), so CSAT (the government agency that certifies and oversees accreditors that are charged with granting accreditation to treatment providers) and accreditors should work together to find solutions to alleviate the problem of high staff turnover.

We shall see whether these findings are acted upon, whether by treatment providers themselves or by CSAT and accreditors. If it turns out that accreditation is not alleviating problems with treatment quality such as this, we hope that policy makers will reconsider the accreditation-based system now in place.

***Federal regulations adopted several years ago require that methadone and LAAM treatment providers be accredited. Providers of other drug treatment modalities do not have to receive accreditation (though some states may have their own accreditation requirements for drug treatment providers).*

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.

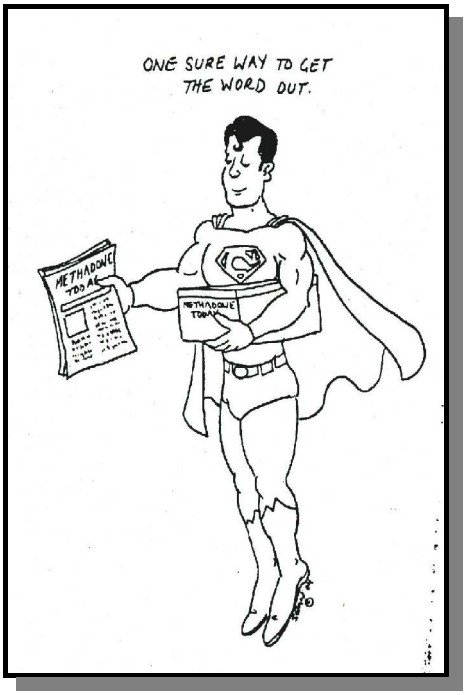
Employment Drug Testing (from p. 1).
a very low dose. Methadone patients sometimes lie/fail to list methadone because they figure they have nothing to lose, but in doing so they are giving a valid excuse for employers to fire/refuse to hire them (i.e., they are not firing you because you are a methadone patient or opiate addict, they are firing you because you were dishonest; whether this is the true reason or not, this gives them a way out of a discrimination charge).

If the drug testing clinic does ask you to provide a list of prescription medications, this may indicate that your employer will only be informed of "positive" drug test results caused by illicit rather than prescribed drug use—another reason to include methadone on such a list. Some drug testing clinics will only ask for a list of prescription drugs if a "positive" drug test result occurs - again, this may indicate that your employer will only be informed of "positive" drug test results caused by illicit drug use, and the employer will not find out that you are taking methadone.

The worst situation is when the drug testing clinic never asks for a list of prescription medications and sends the "raw" drug test results to your employer, not only revealing that you tested positive for methadone but leaving it to you to explain to your employer that the "positive" test result was due to a prescribed medication and not illicit drug use. This is particularly bad in the case of a pre-employment drug screen, since your employer may label you as a "druggie" even before you have a chance to tell them that the "positive" test was due to a prescribed medication. Hopefully your employer will realize that methadone maintenance is a legitimate medical treatment or at least understand that firing/not hiring you because you are in methadone treatment would violate the ADA.

What to do if you are fired/not hired after a drug test? Naturally, if they haven't told you why you were fired/not hired, you should ask them. . . and if they mention the drug test results, ask them to specify what substance(s) was/were found. If they do mention that you tested positive for methadone, reiterate that you are on methadone by prescription and that you can bring verification if necessary. Assuming your employer does not back off of its decision to fire/not hire you, you might want to state that you feel that it is unfair for them to discriminate based on a medical treatment and that you are going to consult with your attorney about whether their actions violate the Americans with Disabilities Act.

If the drug test in question was pre-employment and your employer won't give a reason for not hiring you, you may have a good claim under the ADA. In most cases, employers do not conduct pre-employment drug screens until they have already decided to hire the applicant, contingent on passing a drug screen and/or medical exam. Therefore, an employer is going to be hard-pressed to explain why you were not hired after going through with the drug screen. This is why you do not want to lie/withhold information—that goes not only for prescription medications but also for information filled out on your application or resumè. If you lied on your application, you may have given them a way out of a discrimination suit (i.e., the employer may claim that they did not hire you because they discovered that you lied on your application, not because of the presence of methadone).



If you were currently an employee when the drug test was conducted, you should file a grievance with your union if in a union shop. In a union shop, you are at a real advantage—not only because you have the grievance procedure but also because you have a contract on your side—the collective bargaining agreement, which stipulates that employees can only be fired "for just cause." Therefore, you don't even have to prove that your employer violated the ADA, only that there wasn't a just reason for you being fired.

If you are not in a union shop, you can still sue under the ADA. Either way, you should ask your employer why you are being fired. If your employer does give you reasons besides the drug test results, think about the following: How has the employer dealt with other employees who have been in similar situations (i.e., if you are fired for being five minutes late to work twice in the last two months, how has your employer dealt with other employees who were tardy? Did they only give a written warning to other employees for similar infractions, and how many late days did other employees have before being fired or suspended?)

In case you eventually do pursue a lawsuit, be prepared–-keep a written log as events happen. In court, you will have the burden of proving that you were discriminated against based on methadone/opiate addict status. Chances are, you will not wind up in court, but it doesn't hurt to be prepared.

Hopefully you will never need this information. Many employment drug tests do not test for methadone, and certainly not all employers are going to discriminate against you because you are in methadone treatment. But you should know your rights and be prepared. You should not have to accept discrimination in employment or anywhere else.

Editor's Note: If you have experienced employment discrimination, please send us your story. For that matter, send us ***any*** story relating to opiate agonist treatment (methadone, OrLAAM, or buprenorphine).

Dear Joey **(from p. 1).**

We are glad that you are now doing well. Your story should give other opiate addicts hope that they can recover with the right treatment.

However, your story also reveals a couple of problems with the current system. For example, you stated that when you sought methadone treatment, you were put on a waiting list, so that you did not actually initiate treatment until a year later. Such a long waiting list is not acceptable. While waiting for treatment, an opiate addict could overdose, contract a serious disease (HIV or hepatitis C), wind up incarcerated or even die.

Long waiting lists are often the result of excessive government regulations, local resistance to the opening of new clinics, or in the case of public/subsidized treatment, insufficient government funding. Organizations like ARM/DONT advocate for reforms that would reduce such waiting lists.

Medical Maintenance (from p. 1).

the new federal regulations, which were adopted and went into effect in May of 2001, have given us all good reason to hope that we will no longer have to be second-class citizens. Best of all, these new regulations give patients even at some of the worst clinics a "light at the end of the tunnel." One of the most promising initiatives taken by the Center for Substance Abuse Treatment (CSAT) has been its support for more medical maintenance programs. Until just recently, medical maintenance existed as a very small number of programs, all of them located only in the largest cities, strictly limited as to number of patients and with stringent requirements. This has changed, and now all MMT patients may have a realistic hope of eventually leaving the clinic system behind.

What is medical maintenance, and what makes it so vastly different from the clinic system? In a medical maintenance program, patients visit their program once a month. During this monthly visit, the patient spends a brief time—perhaps 15 or 20 minutes—with the program doctor, who "touches base" with how the patient is doing and writes out the order for a month's worth of methadone at that patient's dosage. The patient gives a urine specimen, then the order is delivered to the program pharmacy and the month's worth of methadone is *dispensed* to the patient as one bottle of solid medication, usually in 40 mg diskettes, although some programs dispense 10 mg tablets. The patient then picks up his 30-day supply from the pharmacy. That's it—no "counseling," no groups, no standing in long clinic lines, no bottles of liquid. . . or the 1001 other hoops we've spent years jumping through. Notice I did not use the word "prescribe"; the legal restriction (placed on methadone alone) still remains, which says that when it is used for maintenance, doctors cannot give patients prescriptions for methadone—but they may *dispense* it. This means that one special, DEA-certified pharmacy must be used (usually one located at the site of the medical maintenance practice); there is no prescription written and handed to the patient to take to the pharmacy of his choice. But in all of the ways that matter most, medical maintenance is exactly like visiting your doctor for any "regular" prescription—except that you won't spend hours in a waiting room when you go for your monthly medical maintenance visit!

Most of us have had the experience of wanting something very badly, waiting a long time for it and eagerly anticipating getting it, but then being slightly disappointed when we got it. But when I started medical maintenance on April 22, 2004, finally leaving the clinic behind for good, actually surpassed what I thought it would be like. What has made such a difference for me isn't a matter of going just once a month; after all, some clinics now offer once-a-month take-homes. The difference is never having to worry again about what new policy may have been put into effect overnight, ready to hit you as you walk through the clinic door; it is being free, at last, of the clinic leash, which can be yanked hard and tight when you least expect it. It is being treated, for the first time in 27 years, with a respect that is genuine—instead of being looked at as though you were something smelly stuck to the bottom of a staff person's shoe. . . I have no words that can express the emotions that flooded over me the day I walked out of the clinic door for the last time as an MMT patient. There was the utter relief of having finally made it out of there--the joy of knowing I'd never be at the clinic's mercy again, but there was also a quiet sorrow that several of my friends—and many, many other clinic patients, who have been taken by HIV or hepatitis C, would never experience this happiness; for them, these changes have come too late.

In future articles, I will be describing how medical maintenance came to my city, how the program was set up and how it's working out now, three months after opening. I will also discuss how the expansion of the availability of medical maintenance, along with other provisions of the federal regulations adopted three years ago, have the potential to radically change for the better, even transform the clinic system itself—and I'll have concrete, practical suggestions about how medical maintenance patients can help make these changes happen, as well as secure the changes which have already taken place. A window of opportunity has opened up for us—one that may never come again—and we must use it!

An important part of making our efforts effective is networking. Most patients who qualify for medical maintenance are people with many years experience as MMT patients—and a hell of a lot of self-discipline. If we pool our resources and work together, we are well-positioned to influence the future of MMT in the U.S. We can help make sure that our knowledge about, and experience with, methadone treatment benefits MMT patients and are considered when policies are being decided. In writing this article and those to follow, I'm taking the first steps to network with other medical maintenance patients. I'm asking all readers who are presently in a medical maintenance program to write me and tell me about your program: where it is located, when it started, how many patients it has, what the requirements for eligibility are, whether it is affiliated with a hospital, an MMTP or other agency, how large the staff is, what formulation of methadone is used, what you pay, etc. Please include any and all comments, suggestions, thoughts; your information AND opinions are valuable.

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