

DRUG ADDICTION SERVICES OF HAWAII, Inc.

# HUI HO 'OMAIKAI IKA POE O HAWAI'I NOVEMBER 2003 NEWSLETTER

Website: [www.dashhawaii.org](http://www.dashhawaii.org)

Vol. 2, No. 6

I want to thank the readers of the *Hui Ho 'Omaikai Ika Poe O Hawaii'i* newsletter. With next year being just around the corner, it is my hope the newsletter will grow to include even better articles; with more information and news about MMT. Here in Hawaii, nationally and internationally....methadone is a controversial subject. One that cannot afford to be ignored. The truth is MMT has given a lot of people back their lives. And if this newsletter can help one person or family member to understand more about this treatment, then we're on the right track !. We are still looking for articles; news events; poems, etc. for future issues. Please leave your submissions for me at the front desk at anytime. *Newsletter Editor: Cricket*

## METHADONE PATIENTS and the TREATMENT of PAIN

Opiate addiction and the most effective treatment for it, methadone maintenance, are not well understood by many within the medical profession. The reasons for this are complex and can be traced back to the *Harrison Narcotic Act of 1914* (*J Payte, Khuri, Joseph, Woods, 94'*). Physicians were the first group to be persecuted by this legislation, which did not consider opiate dependence a legitimate medical condition and forbade the prescribing of opiates solely for the purpose of maintaining dependence. At the time, the majority of opiate-dependent persons were middle class women (housewives) and physicians or other medical professionals who had access to drugs. Nevertheless, many physicians attempted to pursue a humane course of medical treatment by continuing to prescribe their "necessary" narcotics. Authorities were determined to make an example of these mostly family doctors, so many physicians were arrested, imprisoned and lost their medical licenses and practices. It must be emphasized that these were not unscrupulous physicians, rather, many were concerned about the patients they had treated for years. < Continue: Page 2 >

## Patient Education Is Essential

Being a methadone maintenance patient and battling the prejudices that we encounter, is a fact I believe, anyone "not" on methadone can understand. Many patients on MMT have asserted that, "being a methadone patient means fighting an uphill battle against stigmatization and prejudice." A significant number of patients report, "not feeling like they can trust their physician to do the right thing in their case." Aside from the usual questions doctors ask their patients, people on methadone go through "not being trusted...the minute they say they're on methadone." *Cricket* <Continue: Page 3 >

## INSIDE: " HUI HO 'OMAIKAI IKA POE O HAWAI'I :

- Cover Story: " Methadone Patients and the Treatment of Pain " / Continue on .....Page 2
- Cover – 2<sup>nd</sup> Article: "Patient Education Is Essential" / Continue on .....Page 3
- The Opiate-Dependent Person and Pain .....Page 4
- Clinic News : E.I.S., M.I.R., Haumana Advisory-Board (HAB), Hepatitis,Prev,Educ,Trmt.& Suprt.....Page 5
- Clinic News /Cont.: What's All The Fuss? : Take-homes.....Page 6 ; Sunglasses / HepCats....Page 7
- People's Rally; " My Story ".....Page 8

( **CONTINUE: “ Methadone Patients and the Treatment of Pain “** )

Over the years, the medical profession's early experience with the “*Harrison Narcotic Act*” has evolved into the dictum, “stay away from addicts” they are nothing but trouble and addiction is not a doctor's domain. By the 1930's, this attitude became prevalent in medical schools with physicians receiving little or no training in addiction ; which remains to this day. The lack of training on addiction, drug dependence and prescribing medication for pain, has resulted in much confusion among clinicians (*Portenoy & Payne, 92'*). However, there is evidence that the medical profession is changing. Addiction treatment has become a subspecialty within the American Medical Association.

The unwarranted fear of addicts and the fear of prescribing opioid analgesics has been given a name, addictophobia. The education of physicians in the pharmacology of opioids and their ability to relieve pain, along with training the basics of addiction, will help eliminate these attitudes.

**Clarifying Terminology**

Tolerance is a pharmacologic property of all opioid drugs and is characterized by the need for increasing doses in order to maintain the original effects (*Jaffe, 1985*). Tolerance to the reinforcing effects of opioids, and the need to increase the dose in order to maintain the initial effects, is considered an important aspect of addiction. The belief that tolerance will develop to the analgesic effects of opiates in the opiate-naive patient and thus interfere with analgesic efficacy continues despite evidence to the contrary (*World Health Organization, 1969'*). Studies have demonstrated that tolerance to the analgesic effects of opiates occurs only in patients with chronic and worsening pain (*Foley, 1985 ; Twycross, 1983*). Patients treated for prolonged periods with opiate drugs for nonmalignant pain fail to demonstrate the need for escalating doses in order to achieve pain relief. (*Portenoy & Foley, 1986; Portenoy 1989*).

Physical dependence is also a pharmacologic property and is defined solely by the abstinence syndrome or what is more commonly known as withdrawal (*Jaffe, 1985*). Much of the misunderstanding about physical dependence and addiction occurs because these terms are often erroneously used for one another. Physical dependence is a pharmacological property of all opioid drugs, as is tolerance while addiction is identified based on psychological or behavioral manifestations of the underlying disease.

Narcotic addiction as we know it, is characterized by drug craving, compulsive use, deviant behaviors and most commonly, relapse after withdrawal from the drug. It is interesting to note that methadone has a significantly lower potential for abuse than heroin, morphine, etc., based on its slow onset of action with a relative lack of reinforcing effects. The term drug abuse is used to define any compulsive drug-taking behavior that is not within accepted societal or cultural mores. However, experts in the field are beginning to use this term less because of the moral implications, and prefer to use the term “drug use” in its place. It must be stressed that the behavior associated with compulsive drug taking is quite different from the behavior of a patient with a history of illicit drug use who requests medication to relieve pain.

**It must be emphasized that it is unjustified for physicians to be reluctant to prescribe a sufficient dose of medication in order to relieve pain. Since medically caused addiction to opiates rarely occurs, their application to relieve pain should be pursued aggressively and early, in order to promote health and healing.**

**Furthermore, it is illogical for physicians to under prescribe opiate analgesics for patients suffering with the pain of terminal cancer or any other fatal condition for fear of addicting them. For these patients, the focus should be on relieving the pain of the disease and dying and thus allowing them to live out their final days with their family and in comfort.**

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- **NEXT: “ The Opiate-Dependent Person and Pain “ – pg. 4**
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**( CONTINUE from cover page: “ Patient Education Is Essential “ )**

Ignorance about methadone abounds. Stigma and prejudice have kept accurate education about methadone treatment being taught in medical and schools of higher education. The primary source of information about methadone comes from the sensationalized media; and people that don't know what they're talking about, and yet, won't try to find out about the very medication they criticize. Thus, professionals working in the field, supportive services to methadone treatment, law enforcement, health professionals, employers and the public know very little about methadone at all, and what they do know is probably wrong. Even worse is the fact that they don't know that they don't know. And, at the bottom of this is the methadone patient who must bear the brunt of the prejudice and stigma and with no where to turn to. Methadone patients read denigrating newspaper articles and television reports that discredits methadone maintenance treatment and slanders methadone patients – and (some) they believe it. There is no one to reinforce the many accomplishments of methadone patients or to celebrate the many contributions that methadone patients make to their communities. Methadone patients do it alone, frightened and in spite of the opposition against them.

Professionals working in the field receive very little, or no training at all about the very medication that they will be administering. The only training that physicians receive while in medical school consists of about one hour on the topic of addiction, which includes alcoholism. The disease model of opiate addiction is not presented or discussed and therefore physicians do not see opiate addiction as a condition under the domain of medicine. Their education regarding methadone is usually on its use in withdrawing an individual from opiates while its best properties, that of maintenance, are neglected.

And the few interns that do come into contact with methadone patients are usually on the detox wards with the dysfunctional patients. They have never seen or come into contact, with methadone patients who struggle every day, but are determined to stay clean; who in spite of their own past failures, now because of methadone, feel they've been given a second chance at life. Knowing this, it is no wonder that methadone patients are treated so badly by the health and medical professions.

Counselors, social workers and psychologists know even less than the medical professions. They usually receive very little education in basic science and even less about the biology of behavior, or the functioning off the brain. Thus, both medical and counseling professionals have been taught to approach addiction as a character disorder with very little understanding about the biology of addiction.

With such a deficiency within higher education added to the public's misunderstanding about addiction, it is not surprising that myths about methadone thrive. For over thirty years there has been a conspiracy of silence about methadone maintenance treatment. Accurate and scientific information about methadone is rarely presented. The basic education about methadone treatment that professionals receive comes from the same source that the average citizen receive it – the media, which has distorted and sensationalized the majority of methadone information.

### **Education Empowers Methadone Patients**

With such misunderstanding about methadone the only way for methadone patients to deal with it and to ensure adequate health care and supportive services, is to educate themselves. In this way methadone patients can educate others – the providers, supportive services and health care professionals who should know about heroin addiction and methadone treatment, but don't.

If you present yourself as a methadone patient, then you must behave as a role model – no matter how badly they behave or mistreat you, and we all know how difficult this can be. Your behavior should demand respect, and if you are not treated with dignity then go to their supervisor and demand that adequate training about methadone be given to the institutions employees. Write a letter to the president of the hospital, the director of the program, the person in charge and demand a change in the way that methadone patients are treated. Griping for thirty plus years and expecting others to do it has done nothing more than to make the problem worst. We must do it for our own dignity – to receive the adequate health care we deserve from hospitals, clinics, and physicians and to be treated with respect from all the helping professions.

**Methadone Patients as Health Consumers:** Methadone patients must learn to be health consumers when it comes to their medical care. New medications are being placed on the market every day and many doctors may not realize that it can effect your methadone. Make sure that none of the medications that have been prescribed for you will interact with your methadone. As health consumers, methadone patients must insure that the health care they receive, is the quality that they deserve. <END>

## The Opiate-Dependent Person and Pain

Methadone patients who are hospitalized with acute or chronic pain conditions are at high risk for receiving inadequate medication for relief of pain. There are several major reasons for this. First, many health professionals incorrectly believe that methadone patients will obtain pain relief from the methadone. Secondly, attitudes of the medical staff about illicit drug use may overwhelm the need to provide adequate pain relief and complaints from the patients are perceived as manipulations to receive opioids for other than pain relief. Another potential factor for under treatment is the failure of the medical staff to recognize the potential for tolerance in methadone-maintained patients. The result is that a large majority of methadone patients who have needed medication for pain relief did not receive an adequate dosage, or even any at all. As former drug users methadone patients often perceive the medical profession as unsympathetic and prejudiced based on earlier experiences. The rehabilitated methadone patient very often continues to be excluded by those responsible to provide comfort and relief. Whatever factors may contribute to the under treatment of methadone patients, the end result is the undermining of therapeutic alliances.

Some clinicians incorrectly assume that the methadone-maintained patient has no need for pain relief. Patients maintained on methadone have developed a tolerance or resistance to the narcotic, analgesic (pain killing) and tranquilizing properties of methadone. Consequently, they feel pain to the same degree as persons who are not maintained on methadone and need adequate doses of morphine or other narcotics to relieve acute and chronic episodes of pain.

These authors know of no studies that have evaluated the effects of tolerance and its potential in reducing the efficacy of analgesics (*Portenoy & Payne, 1992*). Several studies have found that the usual regimen used to provide pain relief for the non-opiate tolerance patient, can also be used to treat those maintained on methadone (*Kantor, Cantor & Tom, 1980; Rubenstein, Spior & Wolff, 1976*). Since these factors were not considered, these authors encourage clinicians to evaluate dosage in consultation with the patient in order to ascertain that adequate analgesia has been achieved for proper healing and health of patient.

Some methadone patients who have been hospitalized for surgery have reported that their methadone doses were lowered in the hospital and as a result, they experienced withdrawal symptoms while hospitalized (*National Alliance of Methadone Advocates, Inc., 1994*). Other reports have been received, that some patients were even told to detoxify from methadone prior to surgery, since it is incorrectly believed that methadone may interfere with analgesia or their health condition.

**In summary, it must be emphasized that the opiate-dependent patient must be treated with the same dignity and respect as any other patient. When treated humanely and with compassion, the opiate-dependent patient is no more difficult to treat than non-dependent patients, although they may be a little more distinctive than the ordinary patient.**

**Methadone patients or opiate dependent individuals should never be given mixed opiate agonist/antagonist drugs, as this will precipitate the abstinence syndrome and can cause serious problems. Commonly used drugs in this class include: Talwin, Nubain and Stadol.**

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**" A Haumana Thanksgiving "**

- **WHEN:** November 26, 2003 (Wed.)
  - **TIME:** 6:00 AM
  - **WHERE:** DASH

**"EARLY INTERVENTION SERVICES (E.I.S.)"**

@

**D.A.S.H.**

Trained nurses and health educators who provide education, counseling, testing, & support services in the areas of TB, HIV, STD, Hepatitis and more. The next time you are at the clinic, stop by and say "hello" to the gang at E.I.S!.

**"HAUMANA ADVISORY – BOARD (H.A.B.)"**

**Next Meeting's Information:**

- (Date: ) December 12, 2003
- (Time: ) 8:00 to 9:00 a.m.
- (Where: ) Conference Room

**" Methadone Is Recovery " (M.I.R.)**

meetings:

- WHEN: FRIDAY's
- WHERE: Dash's – LUNCHROOM
- TIME: 9:00 TO 10:00 am

**The Hepatitis Prevention, Education, Treatment and Support Network of Hawaii  
and Hepatitis C Global Foundation, Inc., in CA**

- We are happy to announce that Dr. Naoky Tsai & Dr. Alan Tice have both agreed to be our medical advisors when we need their expert advice!

***For more information:***

*Call Ken Akinaka, MRA, Cofounder*

*24-hr. cell phone # 808-221-6204*

## **TAKEHOMES – WHAT’S ALL THE FUSS ?**

It does seem like there has been a lot of fuss with take-homes lately.

The reason there is such a fuss over take-homes is because they are prescription METHADONE. Methadone has been under attack as an evil medication because of diversion since the beginning of time. After the change in Federal regulations recently, again methadone came under attack. We need to do everything we can to preserve the integrity and image of methadone treatment, not just DASH’s but for all clinics.

If a narcotic enforcement or DEA agent finds a methadone bottle on you with someone else’s name on it, or the wrong doctor’s name (because its old), they will immediately suspect diversion. Suddenly, both YOU and the PROGRAM will be suspect.

State Narcotics can request legislation to remove all take-home privileges for the State of Hawaii. We believe that would hurt many of our Haumana who can’t come to the clinic every day for health, work or other reasons, which keep them living a normal life.

Listen, we have enough problems without the take-home issue. If the take-home refill requirements are too difficult for you to manage, then you need to come up with a solution that will avoid the above problems which hurt everyone, or take a look at whether you are not ready to manage take-homes at this time. You can always get them back if things remain stable if you voluntarily give them up for awhile. Otherwise, give us some suggestions.

Recently, for some reason there have been a significant number of bottles coming back squished, label damaged, dirty or sometimes with someone else’s name on it! This is a real concern especially with the college age deaths earlier in the year. Yes, it had nothing to do with us – but that’s not how the public sees it and we need to cross every T and dot every I for now. Protect your program and your reputation!

These situations seem to have increased since we stopped requiring boxes. For those of you who are having the above problems, you may want to consider going back to the boxes for safekeeping.

The bottles are like your prescription refill. Because the methadone is in liquid form, you want to make sure your bottle is clean and dry (because microbes can “come to life” with water and cross contaminate bottles) and with your name on it. Take it on the right dates and be sure to bring it back on the right day too! Our nurse cannot refill a bottle that appears unsanitary for your health.

We are sorry for the inconvenience to those of you having trouble with your bottles. Let’s work together better. We can get more relaxed if you also get more consistent. It’s a give and take. When we relaxed on the boxes, the bottles got worse. Please help – we’re all on the same side. We just want you to get the take-homes as prescribed, as planned and deserved. Let us know if there are other ways we can help other than by just ignoring the rules! < Lisa C. – Director of our clinic >

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- *NEXT: SUNGLASSES – WHAT’S ALL THE FUSS ?*

**SUNGLASSES – WHAT’S ALL THE FUSS ?**

Yes, here’s another thing we are fussing about! Why ?

The staff and particularly the nurses job is to assess each person every day by looking at their pupils, listening to their speech, their large and small motor movements, etc. These things tell her the person is OK to give a narcotic to or that there may be some other physical and/or neurological problem.

We have had people show up going into diabetic shock, impaired, overmedicated on something else, may have had pneumonia, strokes or other problems. The nurse cannot shirk her responsibilities by not assessing because “you know her and she knows you”. We do not want to harm anyone. A simple removal of glasses at the window will do the trick! So what’s all the fuss on the side of the person being dosed? We don’t know. Please tell us! < Lisa C. – Director of our clinic >

**Faces of Recovery Talk Radio Program  
KWAI 1080 AM; November: To Be Announced**

Produced & Hosted by Bruce Berger, M.A.,CRC, CSAC

Faces of Recovery Talk Radio is supported by the generosity of our sponsors:  
*Hawaii Academy Aloha Gymnastics, Law Offices of Steven T. Brittain, and Castle Medical Center*

**“ HepCats ”**

@

The Life Foundation

Every 4<sup>th</sup> Tuesday of each month;  
A free hepatitis C support group

**DASH’s  
“ Hepatitis Support Group ”  
(weekly)**

**Facilitated by Ken Akinaka, MRA**

*( For more information call # 808-221-6204 )*

# " a People's Rally "

@

the State Capitol  
January 23, 2004

Asking Governor Lingle and Legislators to speak and to let the people know  
what they plan to do about the Substance Abuse Treatment problem  
in this legislative session?

## My Story

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M o  
"Chrissy"

- If you would like to share your story, please leave your submission for me at the front desk, at any time. First names only. " Mahalo! "