This is Methadone Today's Anniversary—Seven Years in Print this Month

Methadone Today

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Media Gets it Right--Sometimes

A few years ago, we reported in ***Methadone Today*** about a TV special which included a segment about heroin addiction. They interviewed a couple in the U.K. who were receiving legally prescribed heroin on a maintenance basis. Although we saw nothing wrong with this, we had a real issue with them covering such a rare practice (particularly at that time, very few countries had even experimented with providing heroin to addicts), while not even bothering to mention methadone maintenance treatment (MMT) and that it has the highest success rate of all opiate addiction treatments.

Recently, M-TV did a special on oxycodone/Oxycontin abuse. This time, they actually interviewed a couple who were on methadone maintenance. In fact, MMT was largely presented in a positive light. The woman got on methadone treatment first and was doing so well that her boyfriend, who had also been addicted to oxycodone, decided to obtain methadone treatment as well.

The special was far from perfect. They did not explain that methadone maintenance is the gold standard of opiate addiction treatment or that indefinite maintenance is safe and recommended in many cases. Still, the coverage of MMT in the recent oxycodone special is a definite improvement over the lack of coverage in the aforementioned special/heroin addiction segment of a few years earlier.

Though maybe it is just selective memory on our part, it seems that on average, recent articles in the mainstream media about heroin addiction and opiate agonist treatment have been more accurate and favorable to said treatment than media reports/articles published five or even three years ago. Don't get us wrong--the task of being a media watchdog is far from over for patient advocacy groups. Plenty of articles can still be found, which essentially bash opiate agonist treatment or at least contain inaccurate information. This is often simply the result of poor research by the authors and/or consulting with inappropriate "experts" who are themselves ignorant or have a vested interest in attacking methadone treatment/opiate agonist therapy. But it's heartening to see advocates' efforts begin to pay off. Much of the credit is certainly due to local advocates across the country contacting area newspapers and television news reporters, ***(p. 3)***

Drug Tests--Truth and Consequences

We typically think of drug testing in methadone treatment as pretty straightforward. If treatment is progressing well, the patient should test negative for all illicit/non-prescribed drugs and positive for methadone. Of course, problems can still occur--how frequently, depends on the particular testing laboratory and drug test used... we will delve into this shortly. But one patient we spoke with is being given a hard time by his methadone clinic even though none of his drug tests came back positive for any illicit/non-prescribed drugs or negative for methadone.

In addition to his methadone dose, he is prescribed by a physician outside the methadone clinic a benzodiazepine, a class of drugs which includes Xanax and Valium, and a barbiturate. The drug tests have not come back positive for benzodiazepines. His methadone clinic apparently considers this possible evidence of urine sample tampering and has insisted he provide another urine sample--while supervised by clinic staff. Is this a fair and appropriate response?

Certainly it is possible that this patient did tamper with his urine samples--then again, this is a possibility for any patient, unless the urine test was supervised. According to the patient, he does take the benzodiazepine every day, so at least in theory, there is no reason the urine sample should not have tested positive for benzodiazepines. It is also possible that it is a shortcoming in the drug test itself or the practices of the outside laboratory that conducts that testing and analysis.

To reduce the probability of false positives, cutoff points are utilized when determining the presence of a substance/metabolites. In other words, if the test detects less than X amount of a substance, it is regarded as a "negative" result. In conjunction with an "innocent until proven guilty" philosophy and presumably to avoid lawsuits, the subject is given the benefit of the doubt. For instance, in a pre-employment drug test, the cutoff point will usually be set high enough to minimize the probability of false positive results (drug test result comes back positive even though the subject has not used the drug in question). In most cases, of course, a positive drug test result is undesirable. When it comes to methadone treatment, the only exception to this is ***(Cont. p. 3)***

Update - Rhode Island

B. Miller

Craig Stenning received a Proclamation from Congressman James Langevin and an Outstanding Service award from the Governor of Rhode Island, both the result of letters written representing ARM and MMT patients. When Mr. Stenning accepted the awards, he made it very clear why they meant so much to him—because they were initiated by an advocacy group (ARM). There was a big turnout, and many people had wonderful things to say about this man.

He has been a vocal supporter of MMT patients and mental health patients having their voices heard and being treated with respect. There are many people who say they support advocacy but are not very vocal about it.

Mr. Stenning cares about people. It took him many years to get the methadone program into the jails, many years of work, meetings, and total dedication. Not many people are willing to go that extra mile for MMT patients—inmates especially.

Again, he spearheaded the effort to get methadone into RI prisons. Because of Craig Stenning, RI is the only state that offers methadone in all state prisons to both male and female inmates. I told him about my work with the CT Dept. of Corrections, and he has even offered to meet with them and allow them to tour the facility and the methadone program within the prison.

I had an entire table filled with information—the ***Methadone Today*** newsletter, Watchdog (www.atwatchdog.org) Clinic Report forms, a lot of info from SAMHSA, Methadone Community Education Kits, etc. Almost all of the materials were taken. I made some really great contacts, people who would like to meet with me and discuss what ARM is doing in our area. It was a very nice day.

Thank you, Beth, and the ***Methadone Today*** staff for including the article in the newsletter; almost all of them were taken by the attendees.

There was an Editor's Note on the bottom of ***Methadone Today*** which asked for people to write in about any representatives who are doing special things in the community with addiction, prisons, jails, etc. It is a great idea. Appreciation should be shown to people who go above and beyond.

Please feel free to write and congratulate Mr. Stenning on his award and thank him for his support of advocates and their work. His address is Cstenning@mhrh.state.ri.us

The REAL Motivation Behind High Fees

Posted by R.B. at Watchdog (www.atwatchdog.org)

I honestly think the real hope for methadone maintenance treatment (MMT) patients—newer ones as well as older ones—has "***got***" to be in the direction of office-based opioid treatment (OBOT). I do not think clinics will ever be as they ought to be and were intended by true humanitarians like Drs. Dole and Nyswander. The problem is inherent in the entire drug prohibitionist mind set. As long as that exists and predominates, methadone patients will never be seen as medical patients entirely; there will always be the department of corrections/penal code approach to us.

The problem—or one large aspect of it—is, as you know so well, the built-in power differential between MMT patients (so-called 'clients') and the program staff. It's not overstating the case to say that clinic administrators, and by extension clinic 'staff', have what amounts to a life-or-death power over a clinic's patients. I know that I've seen this power exercised so sadistically, so cruelly, so harmfully, that it has "killed" people, and I suspect many of us have seen it at one time or another.

Public hospitals and health centers regard methadone maintenance as the unwanted stepchild of the medical system; few want to take it on. And I think that we all know that methadone maintenance "ought" to be remarkably cheap. The medication itself is made from far-from-rare raw materials, and the manufacturing process has been around for over 50 years, but the protocols surrounding the medication treat it as though it were radioactive.

Views expressed by the authors are not necessarily the views of ***Methadone Today.*** *We do, however, encourage patients, their family members, clinic staff, and other interested parties to speak out on issues related to methadone maintenance treatment.*

And the process of medicating people with has been made into a ridiculously complicated procedure. I'm speaking here of the contrary-to-common-sense use of "liquid" methadone—with electric pumps, computers, calibration schedules and other nonsense that would be more at home in an ICU.

My God! We are speaking of what amounts to counting "beans" made into a pseudo high-tech rigamarole (and a rigamarole that's laughably vulnerable to staff diversion, spills, leaks, poor calibration mistakes, etc., etc. All "that", of course, can be laid at the door of the drug companies who sold some MMT directors on adopting such a silly system. . . but my point is, that "all" such procedures tend to accrete around MMT providers because it's in the self-interest of these programs to have a big, bad drug mystique surrounding methadone—hence the locked boxes, the endless and often arbitrary rules, the big deal made about 'confidentiality'—when it serves "their" purpose—while they violate patient confidentially at every turn when it suits them.

Conversely, typical programs, which view the patient as some sort of parolee—whose parole never ends—attract and "keep" the kind of staff who find the kind of power they are given enjoyable and even intoxicating. It's a vicious circle, and "monitored urines" are a good example of it. How can the relationship between a staff person and a "client" be anything other than degrading for the patient when the staff person actually watches the poor bastard urinate! This is so demeaning, and it's characteristic of the whole staff-patient dynamic.

My program for example, like so many others, still "monitor" urines. A new "counselor", who heard about methadone for the first time at her employment interview, eyeballs the patients so closely when they are urinating that one girl asked her if she was hinting for a date!

There has been such a turnover at this clinic that we joke that half the town has watched us pee! Seriously, a private physician writing a prescription is so much more cost effective! As for "counseling", you know yourself that anyone who takes that title seriously and tells his/her business to these people will eventually regret it. Anyone needing counseling should get it elsewhere!

As for insurance companies covering MMT. . .since most of us on the board (Watchdog Forum) are on maintenance and not candidates for withdrawal, it's unlikely that any insurance carrier is going to pay for what amounts to indefinitely long treatment. . .and certainly not at the inflated prices clinics charge. From what I've heard, six months is about the best that can be hoped for.

Of course, if we were under an OBOT modality, the cost of treatment should amount to nothing except the price of the prescription itself (which certainly "should" be negligible) and the monthly doctor's visit. From a common sense viewpoint, it's clear that not all methadone patients can or should automatically be eligible for OBOT. The potential for bad apples to screw it up for the rest of us is just too great. But certainly much of the "unnecessary" red tape surrounding MMT "could" be alleviated if it were simply a "part" of regular health services offered by already existing hospitals, etc.

For one thing, the physical plan is already there—no office space/building need be leased; there is abundant security at hospitals, etc. All of that is usually overhead for a regular clinic. And patients would have access to real professionals—both M.D.s and others, rather than the usual collection of old drunks and bottom-feeders who presently are the only doctors willing to work at MMTs.

I "do" think—and hope—that the new regs "will" be of some help. But clinics, for the most part, have to be dragged kicking and screaming to follow the new protocols about urines and extended takehomes.

That is not going to change quickly. I think that only programs that are integrated into a general health institution have a likelihood of being the kind of program we all want to see.

One last point, then I will end this too-long post: MMT programs could benefit immensely from the knowledge and experience from people who've been successful with methadone treatment for a long time could offer. My understanding is that it's okay for active methadone maintenance patients to work at programs as long as you don't work at the same program where you are a patient. But I recall years ago having counselors who were patients as well as staff.[1]

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[1] Patients can work at the same clinic where they dose, although it is discouraged. The only thing a patient/employee cannot do is sign for deliveries of methadone and be in the dosing area.

Drug Tests (from p. 3).

when testing for "methadone", in which case a negative test result is undesirable. Treatment providers generally interpret such a result to indicate that the patient is either not taking his methadone as prescribed and/or is somehow tampering with the urine sample (i.e., diluting the sample or using someone else's urine). Otherwise, for the other drugs tested—including benzodiazepines—a positive test result is normally considered undesirable, though in individual cases may be considered acceptable if the patient has been legitimately prescribed such a medication. Thus, laboratories set higher cutoffs with this in mind, even if this means that some false negatives will occur.

For various reasons, different laboratories may utilize different cutoff points for the same substances. Therefore, it is possible that the laboratory currently being used by this patient's clinic may have a higher cutoff point than other laboratories. In fact, the patient says that he used to go to a different clinic where the drug tests always came back positive for benzodiazepines, even though he was on the exact same dose of the same prescription then as he is now. Perhaps, this is the explanation—that the laboratory used by his former clinic utilized a lower cutoff point for benzodiazepines than the laboratory used by the clinic he presently goes to. In any case, mistakes do occasionally happen—why is it always automatically assumed that the patient is lying or cheating? Guilty until proven innocent?

The patient in question has been in treatment for some time and has "earned" take-homes and has had them for quite a while. By all other indications, aside from the aforementioned drug test results that the clinic deems suspicious, he is stable, functional and trustworthy. He has attained steady employment, stable family life, no legal trouble, appears to not be abusing alcohol or other drugs, etc. The reasonable course of action in this case is to not automatically assume that the patient is guilty of wrongdoing with regard to the urine sample/ drug test.

If the treatment provider is convinced that something is amiss, wouldn't it make sense to just have the urine sample retested by a different laboratory and/or possibly using a more accurate/sensitive test? If the cost of such a retest is an issue, a compromise could be worked out. If the second test comes back negative for benzodiazepines, the patient pays for the test (this is the way most clinics do it); otherwise the clinic pays. After all, if the retest comes back positive for benzodiazepines, the issue should be resolved—the clinic will realize the next time the test comes back negative for benzodiazepines, that it is just a problem with the laboratory or the test itself.

Instead, his clinic is insisting on conducting another drug test. But this time, the patient will be supervised when providing the urine sample. They do not see anything intrusive or offensive about such a practice, and many treatment providers share this view. To this day, some providers supervise all patients--for every urine test.

This seems unfair to the patient when there is a distinct possibility that the patient did not tamper with his urine sample. There are other less intrusive methods of verifying the accuracy of the test results and potentially ruling out the possibility of patient sample tampering. And what of patients who are unable to urinate while being supervised?

There is yet another way to verify whether the patient has used illicit drugs and consequently whether urine sample tampering may have taken place—oral swabs. A drug test is currently available that utilizes saliva instead of urine. Most patients find this less intrusive and less embarrassing than urine testing—more so, when urine testing is supervised. Normally, oral swabbing is done under supervision, so sample tampering is not an issue. Obviously supervision is not nearly as problematic and embarrassing as supervision of urine testing.

If the oral swab test yields negative results for illicit/nonprescribed drugs, it is fairly safe to assume that the patient did not tamper with the original urine sample. Who would bother to tamper with a urine sample if they have not abused any drugs? On the other hand, if the swab test yields positive results for any illicit/nonprescribed drugs, then suspicion of urine sample tampering may be warranted—in which case the clinic could continue to use the oral swab test in conjunction with urine testing, or use supervised urine testing to ensure tampering is not taking place. Even so, if supervised urine tests still come back negative for benzodiazepines, the clinic is back to square one--this would again call into question the accuracy of the urine test, at least when it comes to benzodiazepines.

Even more than the humiliation of having to urinate in front of someone, the lack of trust shown by some clinic staff is what hurts most. A patient can show years of negative urinalyses and be a productive, trustworthy person, but they are still guilty until proven innocent in the eyes of the treatment provider.

The drug test was supposed to be just an ***aid*** in the patient's treatment. It was never meant for clinic staff to feel that "I gotcha" if a test came back positive.

Drug tests are not infallible, and unexpected or inconsistent results should be handled in a manner least humiliating and intrusive to patients. Alternatives to supervised urinalysis do exist, and that includes starting with trust in the patient when there has not been evidence of wrongdoing in the past.

Media Gets it Right (from p. 1).

and giving them material supporting the medical value of opiate agonist treatment. It certainly helps that the weight of medical evidence is on your side. No doubt, the change in the federal regulations has also helped change attitudes in the media--both by forcing the media to pay more attention to the issue and by allowing them to rethink their pre-existing misconceptions about such treatment (i.e., if methadone maintenance is all that bad, why would federal policymakers adopt more lenient and less restrictive regulations for the treatment?).

Patient advocates need to keep up the good work. We also urge methadone patients not already involved in advocacy to write or call your local newspaper or television news station when you see a story related to opiate agonist treatment or opiate addiction. You can write in anonymously if you do not want everyone to know about your addiction history/methadone treatment status. Tell the reporters about your own experience with treatment and point out any factual inaccuracies you notice in their story. The stigma surrounding opiate agonist treatment will never be completely erased until we all become media watchdogs.

Please don't forget to vote in November. If you are not registered, get registered **NOW.** You can't wait until the last minute but have to be registered several weeks prior to the election. It is very important that you find out what your Representatives and Senators in Congress have voted for in the past. If they don't vote in your interest, oust them and get someone in who will look out for you.

From now on, ***Methadone Today*** will be printed nine times per year instead of ten: February, March, April; June, July, August; October, November, & December. There will be no January, May, or September issues. We hope this won't cause our readers any inconvenience. Thank you for your understanding.

Buprenorphine Update

by Chris Kelly

SAMHSA/CSAT held a "Buprenorphine Stakeholders Meeting" on July 26. 2002, in Bethesda, MD. The big question, "**When** is the FDA going to approve buprenorphine for opiate addiction treatment", was, unfortunately, not answered. Although there were representatives from the FDA, Schering Plough, Reckitt and Coleman, and the DEA at this meeting, no one would say "when" this livesaving and critical medication will be approved.

That said, there were some interesting developments discussed. The first is that CSAT and the DEA have "certified" 170 doctors to prescribe buprenorphine so far. The Drug Abuse Treatment Act (DATA) enacted in 2000 amends the Controlled Substances Act (CSA) to allow qualified physicians to apply for waivers of the Narcotic Treatment Act and the CSA registration so that they may dispense or prescribe certain Schedule III, IV and V controlled substances specifically approved by the FDA for opiate addiction treatment. Although there are no FDA-approved medications available at this time, these 170 doctors will be able to prescribe buprenorphine the day the FDA approves the medication.

Additional information on DATA, including the Standard Notification Form which physicians must complete to become buprenorphine providers, may be found at www.buprenorphine.samhsa.gov. If readers know of any doctors who would be interested in adding opiate addiction treatment to their practices, we urge you to visit this website. The Federation of State Medical Boards has also developed Model Policy Guidelines for Opioid Addiction Treatment in the Medical Office, available at the FSMB website at www.fsmb.org.

Under the terms of DATA, these physicians must be "qualified." There are several ways for doctors to demonstrate that they are qualified: ASAM, AOA certification, participation in a clinical trial, eight-hour training provided by ASAM, AAAP, AOAAM, APA, etc. There are also online courses available. Approximately 2,000 U.S. doctors have taken the courses, although they have not yet submitted the required Standard Notification Form to CSAT.

One other restriction of DATA is that these physicians will also certify that they will treat no more than 30 opiate-addicted patients at one time. The DEA will be responsible for monitoring this 30-patient limit. In addition, certified doctors will get a "buprenorphine specific" DEA number which must be used on all buprenorphine prescriptions. DEA field officers will include two certified buprenorphine practitioners in each of their quarterly work plans. They will inspect for patient numbers, record keeping and, if applicable, security.

The question was asked "What about a MTP doctor who wants to provide buprenorphine? Will they be restricted to 30 patients?…..the short answer was "no", but if a MTP wants to provide buprenorphine, the medication will have to be subjected to the same rules as methadone and LAAM (i.e., takehomes, urinalysis, etc.). I personally see no reason why someone would get buprenorphine via the MTP system when they can get it from a doctor, with a 30 day prescription, no urinalysis, no groups, and no MTP hassles. Also, there is the cost factor. Buprenorphine via a doctor's prescription will be covered under regular health insurance, so the patient will only have to pay regular co-pays. Why would anyone want to pay hundreds of dollars out of pocket for buprenorphine at a MTP when it will be accessible via the mainstream medical system? I doubt that many MTPs will offer buprenorphine unless it is set up as a totally separate medical maintenance program, and there is confusion if such a setup would be restricted to 30 patients.

According to the National Pharmacy Compliance News, as an important related matter, the DEA published a proposed rule in the March 21, 2002 Federal Register that would reschedule buprenorphine from a schedule V to a Schedule III. This DEA action is based upon a formal rescheduling recommendation from DHHS. The DEA rescheduling proposal is based upon "new information" available since the initial scheduling review of buprenorphine in the 1980s. The rescheduling action, when finalized, will not affect the use of buprenorphine products approved by the FDA for the treatment of opiate addiction. This notice states that the FDA has issued approval letters for two products (Subutex and Suboxone), and they are likely to receive final marketing approval in 2002.

It is important that readers let the FDA know that we need this medication approved now. As indicated above, buprenorphine has been available for pain treatment in the USA for over ***twenty years***. Other countries, including Britain, approved the opiate treating formulation (which is at a much higher dose than the pain formulation) as a matter of course, with no delay. Unfortunately, because of the War on Drugs mentality in the USA, this medication, which should be available from any doctor who takes the 8-hour training course, is still being held up by the FDA.

Please, write to the FDA at www.fda.gov and let them know that we need this medication approved now. The doctors are ready, the patients are ready—why is it still being held up?

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