

Methadone Today

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Abuse in Therapeutic Communities

A recent DRCNet article examined abusive inpatient drug treatment facilities--so-called "therapeutic communities." Apparently, abuses by these therapeutic communities are ongoing and substantial, yet the mainstream media has primarily portrayed them as a tough but effective quick fix for drug addiction (along with so-called "boot camps", deceptively cast as a cure-all for troubled young people [no matter what the problem]--even though physical abuse is not uncommon and there is evidence that they are no more effective than prison). [For another example of poor media coverage, see p. 4, "Case Studies in Spotty Journalism."]

The mainstream media has completely ignored the string of serious abuses therapeutic communities have perpetrated over the years. DRCNet's report documents that the abuses and other problems with therapeutic communities cannot be explained away as a handful of isolated incidents. Aside from the cases of physical abuse, most therapeutic communities apparently operate like religious cults rather than medical centers. This is NOT what drug addicts need. Drug addiction is a medical condition, that should be handled by medical treatment--a treatment demonstrated effective by research and not created based on outdated concepts of addiction. Though some of the current therapeutic communities may claim to have incorporated the "disease concept" of addiction into their programs, the theory behind therapeutic communities is that drug addiction is not a "disease" at all--at least not in the medical sense of the word. The general philosophy behind most therapeutic communities appears to be that drug addicts are weak people: spiritually, morally, and mentally. This is completely contradicted by research and thoroughly rejected by mainstream medicine.

So what's the point? That drug addicts and/or their family members should do some careful research before buying into a therapeutic community's [or any other drug treatment program's] slick sales pitch? But there's another issue to consider: should the government be funding or subsidizing such programs? Therapeutic communities happen to be a popular drug treatment modality with the criminal justice system. But there is also the issue of government funding outside of the criminal justice system--specifically, does President George W. Bush's funding of **(Cont. p. 3)**

What is Methadone?

[The following is reprinted from the handbook, "About Methadone," published by The Lindesmith Center-Drug Policy Foundation.]

Methadone is a long acting, synthetic, narcotic drug that was first used in the maintenance treatment of drug addiction in the United States in the 1960s. It is an opiate "agonist," which means that it acts in a way that is similar to morphine and other narcotic medications.

When used in proper doses in maintenance treatment, methadone does not create euphoria, sedation, or an analgesic effect. Doses must be individually determined based on a person's body weight and opiate tolerance. The proper maintenance dose is the one at which the cravings stop, without creating the effects of euphoria or sedation.

Although methadone is not a single product from a single manufacturer, the active ingredient is always the same: methadone hydrochloride. All manufacturers add a small number of additional inactive ingredients, such as magnesium stearate and cellulose. Some of the U.S. companies that manufacture methadone include cherry or orange flavoring. Methadone is dispensed orally in different forms*, which include:

- Tablets, also called diskettes. Each one contains 40 milligrams of methadone, is dissolved in water, and then is administered in an oral dose. The primary inactive ingredient in the tablet form is colloidal silicone dioxide.
- Powder is also dissolved in water.
- Liquid methadone can be dispensed with an automated measuring pump. Dosages can be adjusted to as small as a single milligram.

Patients have different opinions about the various types of methadone. Some prefer the dissolving white tablet, some the orange, and some the liquid form. Each methadone provider usually offers a single type of the drug and obtains its supply from one source, which means that patients generally do not get to choose which form of methadone they get.

For most people, a single dose of methadone lasts 24 to 36 hours.

How is methadone different from heroin and other opioids (for example, morphine or Dilaudid)?

- Methadone lasts longer. The body metabolizes methadone differently than it does heroin or morphine. **(Cont. p. 3)**



Dear Methadone Today,

I have been an avid reader of **Methadone Today** since I first went through a copy over four years ago when I began methadone maintenance treatment at Clinic X.

It was right about the same time your publication was taken off the shelves at our clinic, WITH NO REASON GIVEN. Myself, I believe the Directors took your publication off the shelf because it contained information, "DANGEROUS" INFORMATION--such as how arbitrary dosing caps can be torturous to certain individuals, etc. etc.--any kind of "information" that might in any way question or challenge that status quo of the "clinic system," OR, a particular practice or procedure that has been proven to be outdated, inhumane, or impractical by the medical community, or by study and research.

I am writing you today, mainly, to just let you know that your publication and your efforts can NEVER be overrated and

should never be taken for granted--(but also to relate the problems I have had getting a dosage increase). I have traveled around the state, introducing myself and basically asking one and only one question of the Intake Director: "What is your policy regarding a dosing cap/What is your cap?/Is there a cap?" I was amazed to find that every single clinic stated 100 mg. as their cap, and only two were willing to consider giving a "client" above that, and that it would require extreme circumstances for that to happen. Basically, the pat answer everywhere I went was: "transfer here first, and we will consider your options then."

As of today, I remain stuck at my clinic on 100 mg., for a number of reasons. I do not have reliable transportation, have run completely out of money, every member of my family is ENTIRELY ANTI-METHADONE regardless of the remarkable turnaround I have made regarding sobriety, ALONG WITH MY FIANCE--WHO ONLY BELIEVES METHADONE HAS MADE ME LAZY, ETC. Contrary to their armchair medical logic--a dose increase would give me more energy, not make me apathetic. **(Cont. p. 3)**

More on Opiates, Pain and Addiction

Recently posted on Yahoo's internet website was a medical question, along with an answer by Dr. Dean Edell. The individual asked why her doctor was switching her from Dilaudid (a short-acting opiate) to methadone. She thought that methadone was only for the treatment of heroin addiction, and she is not a heroin addict. Many people do not realize methadone's utility in the treatment of pain.

In Dr. Edell's answer, he states, "the problem is that methadone and all the other opiates are addictive. You cannot stay on methadone for months at a time." Although it is technically correct that opiates are addictive, it is potentially misleading. We would have liked the doctor to explain that in the context of pain management, only a very small percentage of patients will become addicted to opiate medications, even when prescribed on a long term basis.

The difference between addiction and physical dependence was not explained--a distinction that we have mentioned numerous times in *Methadone Today*. The doctor states that one, "cannot stay on methadone for months at a time." It is correct that an individual could not use methadone or any other opioid on a daily basis for months at a time without becoming physically dependent on the medication. However, as we have indicated above, most patients who take opiate medications on a long term basis do not become addicted. When they no longer need opiates for pain control (although there are patients with chronic pain who will need these medications to control pain for the remainder of their lives), they will simply stop taking the pain medication and this will be the end of it. This is to say that they may experience opiate withdrawal symptoms, but once these temporary symptoms pass, they will not crave opiates or exhibit drug-seeking behavior.

So, it is obviously true that the prescription of opiates on a short-term or long-term basis entails some risk that the patient will become addicted, but the risk is small and not as serious as the potential complications associated with not properly treating pain. Proponents of adequate pain control point out that patients who receive aggressive pain control recover faster and respond better to medical treatments. Many doctors do not seem to recognize that under treatment of pain is serious business. There have been numerous reports of patients attempting suicide because they could no longer live with the pain. One patient in chronic pain approached Dr. Jack Kevorkian, a doctor well known for helping patients with chronic, untreatable diseases to commit assisted suicide. Dr. Kevorkian declined and instead advised the patient to find a doctor willing to prescribe adequate pain medication.

Doctors prescribe medications all the time that have potential to cause harm. When it comes to drug addiction, there are plenty of prescription medications besides opiates that have the potential to cause addiction. For example, though there has been some media discussion about whether Ritalin is over prescribed, virtually no physician would argue that Ritalin should never be prescribed on a long-term basis. Why? Because in many cases, the beneficial effects of the medication outweigh the potential for addiction.

The under treatment of pain is an all too common problem, with a number of causes, as the article below explains. As discussed in this article, the typical mistake doctors make is under prescribing opiates--the other side of the coin to Dr. Edell's statement to the effect that doctors not experienced in the treatment of pain are typically guilty of over prescribing opiates/prescribing opiates when they shouldn't be. We wish Dr. Edell had set the record straight about the utility of opiate pain relievers.

Medical Journals Cover Pain Management

[Dr. Andrew Byrne provided the basis for this article]

Recently, medical journals have devoted significant space to the important issue of pain control. In their April 21, 2001 issue, the Lancet wrote about the under treatment of pain and the reasons it continues to be a problem. Their list of reasons were as follows:

1. A "cultural attitude" that "pain is something to be endured without complaint."
2. A "persistent, irrational fear of opioid addiction," resulting in excessive government regulations on the prescription of opioids that "prevent" or "discourage" the provision of "effective pain control."
3. Insufficient education of doctors that leaves "doctors feel[ing] unprepared to assess and treat difficult pain syndromes."

At the same time, JAMA (Journal of the American Medical Association), in the April issue, also wrote an article about the under treatment of pain. The article indicated that an estimated "17% of Americans have serious chronic pain and many go untreated." They quoted Richard Brown, M.D., MPH, Associate Professor of Family Medicine, that "acute pain and cancer pain have been under treated," and "the most egregious under prescribing occurred with idiopathic back pain, the most common kind [of pain]." Thankfully, the issue of inadequate pain control is getting some attention; hopefully physicians will take notice and begin taking pain seriously.

Fear & Ignorance

Peter Moinechen

Center for Addictive Problems (CAP)

Methadone ignorance can be combated by education, and the science that backs up this education is indisputable. But facts do not impact fear. Fear is a primitive emotion. I believe one component of this fear is that opiate addicts do not want to own that chronic disease called protracted endorphin system derangement.

Some addicts' systems will re-balance themselves during abstinence. These should be the most grateful. Others, due to biology beyond their control (powerlessness), find their opiate receptors starving for endogenous opiates throughout their lives. For these, the comfort of stability is an unattainable goal without the introduction of exogenous opiates. The introduction of medicine to treat a disease is usually met with hope, but the medicine that is methadone is met with jeers.

Could fear be fueling these negative beliefs? Fear that if I did a searching inventory of my health status, I may discover that I function at an improved level when more of my opiate receptors are filled. If comfort and recovery are to be married, for many opiate addicts, methadone must be the best man.

Discomfort and instability are not hallmarks of recovery--rather, quality of life, improved function, and increased range of choices are what we strive for. To condemn someone to the ravages that accompany the brain disease of addiction when effective medicine is available is unconscionable and rather should be emphatically embraced as a viable, authentic tool that saves people's lives. For 12-step programs to deny the benefits of their meetings, deeper contact with our spiritual nature, and fellowship to methadone maintained recovering persons is a crime that cries out for redemption.

Therapeutic Communities (from p. 1)

"faith based initiatives" include these therapeutic communities? Some politicians, such as President Bush and Senator John McCain have hinted that they strongly approve of such drug treatment methods. Instead of allowing politicians to hide behind such terminology (i.e., faith-based initiatives), we should insist that any government funding of drug treatment-in the criminal justice system or elsewhere--should go toward drug treatments proven effective and safe, such as methadone maintenance treatment.

What is Methadone? (from p. 1)

When a person takes methadone regularly, it builds up and is stored in the body, so it lasts even longer when used for maintenance. Most people find that once they're stabilized on a dose of methadone that's right for them, a single oral dose will "hold" them for at least a full 24-hour day. For some, the effect lasts longer; for others it lasts a shorter time.**

➤ Stability is easier on oral methadone. Most people who are on a stable, appropriate dose of methadone for several weeks will not feel any significant sense of being "high" or "dopesick." Some patients may feel a "transition"--or temporary, mild glow--for a short time several hours after being medicated, however. Others may feel slightly "dopesick" prior to taking the day's medication, but most will feel very little or no effect from the proper dose of methadone once they have stabilized.

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*(referenced from pg 1). As has been previously noted in **Methadone Today**, the new federal regulations permit methadone to be dispensed in solid form. Under the former regulations, methadone for the treatment of opiate addiction had to be dispensed in liquid form. Providers had to use the liquid methadone or add water/juice to powder or diskettes prior to dispensing. However, some states may still require it to be dispensed in liquid form. Therefore, methadone patients may receive a tablet (this is to be distinguished from the "diskettes" which are dissolved in liquid and subsequently drank) that is simply swallowed, in addition to the other "forms" of methadone mentioned in the above article. Thus far, such tablets have been largely reserved for patients receiving 14- 30-day takehome supplies.

**Some patients, who metabolize methadone at a relatively rapid pace, may need their daily dose divided into two or more parts to be taken over the course of the day (i.e., a patient on a daily dose of 100 mg. may take 50 mg at 6:00 a.m. and the remaining 50 mg

at 6:00 p.m.). Such dosing practice is commonly referred to as "split dosing." Many patients requiring split dosing have hepatitis C. Depending on the progression of the disease, it may cause the liver to metabolize methadone more rapidly. We hesitate to make generalizations--it is actually possible for Hepatitis C to even SLOW down the metabolism of methadone, although this seem to be less common. The use of other medications may also speed up or slow down the metabolism of methadone (i.e., certain HIV medications may speed up the metabolism of methadone). When taking medications that speed up the metabolism of methadone, the patient may require split dosing, but more often, a dosage increase may be all that's necessary.

Dear Methadone Today (from p. 1)

For my own part, when I had money in the bank, I chose to supplement and hope



MAN... I SURE AM GLAD
CHRISTMAS IS OVER
FOR ANOTHER YEAR!
I GUESS ALL THOSE FOLKS
THAT SAY THE BIG GUY
DON'T EXIST, SHOULD
TRY PULLIN' HIS
BIG OLE' BUTT!
ALL NIGHT!



BACK TO THAT!

Anyway, again, your publication is doing so much to help others--thank you.

Dear Reader,

Thank you for your kind words. Do not lose hope that your dosing issue will be resolved favorably. We are hopeful that accreditation organizations will follow through on CSAT's statements that dose caps will not be tolerated. This applies to explicit clinic dose cap policies and also to unofficial practices (i.e., clinics where there is no actual dose cap **policy**, but in reality, the doctor never (or virtually never) prescribes doses above a certain level, even for patients who have asked for and clearly need a dose above this level. Some methadone treatment providers have not come up for accreditation under the new federal regulations yet, but those that haven't will shortly. To be accredited, those treatment providers that still have dose caps will have to eliminate dose cap policies and practices according to accreditation standards.

We are certainly not convinced that accreditation will eliminate all cases of underdosing by methadone treatment providers; however, we are hopeful that it will eliminate or at least curb across-the-board dose ceilings and reduce the number of patients who are seriously underdosed. Perhaps it would be naive to believe that accreditation in itself would force methadone clinics to provide excellent care, but accreditors can at least push them to enact policies and provide treatment roughly in sync with guidelines and "best practices", as determined by experts. We suggest you contact CSAT about your clinic's dose cap policy.

Regarding receiving treatment from a private physician, it is really the office-based setting, along with reduced attendance requirements, and the lack of clinic-style rules that makes office-based opioid treatment (OBOT) so attractive. Another likely advantage of OBOT is in treatment cost. It is likely to be far cheaper, since patients only attend the doctor's office once a month.

We wish you luck in getting the quality treatment you deserve, either at a clinic or a doctor's office. Clinics will have to terminate dose cap and other blanket policies or risk losing accreditation.

Have a great Christmas and New Year; we'll see you in February. There will be no January issue of **Methadone Today**. Thanks to those of you who support the newsletter. To those who haven't donated or subscribed, please do your part in 2002. We need your support. Thanks.

for a change at my clinic to magically materialize. Now, on unemployment and barely able to even meet my weekly clinic fee, I am scared to death of the prospect of having to detox for lack of funds. Yes, I've been put on a waiting list at a State/sliding scale clinic--but I guess I APPEAR fully functional or to be from a family of wealth, or whatever. It just seems that you have to lie about being broke if you are to have any hope of getting any financial assistance, and then remain that way, while waiting for something that might not come for months: admission to the clinic. My one hope, as I see it, appears to be canvassing pain specialists or private M.D.s who would consider prescribing me Dolophine [methadone tablets] on a private basis, which to me, has seemed to be the "holy grail" for all methadone advocates for years. To me, it seems my only hope is to find a private physician willing to prescribe methadone under a "pain management" umbrella/setup, or detox off (this is not favorable) and take my chances with painkillers and H... NO, I CAN NEVER GO

City to Allow Medical Maintenance

The San Francisco Examiner reports that San Francisco will begin allowing physicians to, "prescribe methadone directly to heroin addicts [out of the doctor's office]."* This program will be funded by the federal government via a \$1.1 million grant. Such medical maintenance or OBOT (office-based opioid therapy) arrangements are feasible since the adoption of new federal regulations permitting it. Under the former federal regulations, physicians could theoretically provide methadone maintenance treatment out of their private offices, but to do so, they would have to be specially licensed (only licensed opiate treatment providers could dispense or prescribe methadone for the treatment of opiate addiction), adhere to extensive paperwork requirements, and have to adhere to a extensive, rigid set of rules, including those covering how the medication is to be stored--and physicians could not merely write a methadone prescription for a pharmacy to fill. All this virtually ensured that no physician would be willing or able to treat patients out of his/her office, and besides, the take-home rules under the former federal regulations only allow patients to receive a 6-day supply of take-homes--so patients would have to attend the doctor's office at least once a week to dose, not a very realistic situation for the patient or the physician.

On the other hand, the current federal regulations allow medical maintenance/OBOT under certain arrangements and give CSAT (the federal agency overseeing the enforcement of the regulations) the ability to approve other arrangements. So far, CSAT appears to be very open to OBOT arrangements. According to the San Francisco Examiner, "the federal government has waived certain methadone distribution restrictions for local governments with specific plans for expanding treatment of opiate addicts." The federal take-home rules no longer serve as a barrier to medical maintenance, since they actually permit it up to 30-day take-home supplies for patients who have been in continuous treatment for at least two years if they meet certain other eligibility requirements. Thus far, this is the first city, county or state organized or precipitated medical maintenance program to be created since the adoption of the new regulations. In many states, patients have begun to receive 14- 30-day take-home supplies [attending the treatment provider's facility only once or twice a month], but generally these patients are getting treatment from methadone clinics, not in an office-based setting.

We are anxious to see this program begin. Other cities may organize their own OBOT programs once they see OBOT work in San Francisco. States which currently are not permitting OBOT may also be persuaded to allow it. While a few pilot medical maintenance programs have been operated in the United States (the most notable one in New York), they received scant attention and were single facility

operations that were only permitted to treat a small number of patients--and at least in the New York pilot, patients were carefully selected using extensive eligibility requirements. Many cities and states have been slow to embrace medical maintenance/OBOT, in part due to the lingering stereotypes regarding opiate addicts. But if OBOT is successfully practiced on a citywide basis (i.e., in San Francisco), state and local policymakers will be forced to acknowledge that it is practical and beneficial.

Thus, the San Francisco OBOT program has great potential--not just for San Francisco residents, but for methadone patients across the U.S. who just want to receive maintenance treatment from a doctor's office instead of a clinic and for opiate addicts who are currently on a waiting list for treatment. OBOT providers increase access to methadone treatment by taking patients who were formerly going to a methadone clinic--opening up treatment slots at the methadone clinics. Advocacy groups like ARM deserve recognition for helping to make medical maintenance a reality, and we urge them to continue working to make OBOT available in the U.S.

*"City's New Heroin Program Enlists Doctor's Help," Eric Gershon, San Francisco Examiner (October 30, 2001).

Therapeutic Communities, Bootcamps, and UROD: Case Studies in Spotty Journalism

The media's selective reporting on therapeutic communities and boot camps is reminiscent of its coverage of UROD (Ultra Rapid Opiate Detoxification or so-called "rapid detox"). From the beginning, UROD made front page headlines. Many of these news stories were skewed, devoting a great deal of space to quoting/interviewing UROD researchers and practitioners (individuals who stood to gain monetarily from the treatment), and very little space to skeptics. The media appeared to be exceptionally trusting of UROD proponents, and the media's enthusiasm with this treatment was not the least bit dampened by the fact that very little research was available to either affirm or contradict proponents' claims that the treatment was safe and highly effective. Meanwhile, the media overlooked and largely continues to overlook, all the people who underwent UROD and had bad experiences. The editors of **Methadone Today** have been contacted by a large group of people who had very negative experiences with UROD. When evidence began to accumulate that UROD may not be as safe or effective as its proponents originally claimed, the mainstream media did not report it--or where they did, the report was placed on an inconspicuous back page. In fact, one could scarcely find anything about the alleged dangers of UROD outside of professional medical journals and newsletters. [See "Therapeutic Communities" on p. 1]

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