

# Methadone Today

The official newsletter of DON'T-BY PATIENTS, FOR PATIENTS July 2002 Volume VII Number V

## Scattered Thoughts

By Peter Moinechen (CAP Quality Care)

Methadone maintenance is a scientifically proven effective treatment, as demonstrated by NIDA, for regulating the endorphin system derangement commonly referred to as opiate addiction. Yet some substance abuse treatment providers consistently feel that the goal of treatment is the elimination of the replacement medication that balances a system in disarray. To withdraw the stability provided by opiate agonist therapy is to push the endorphin system and the patient back towards chaos. Treatment providers' beliefs based on magical thinking rather than science result in totally inadequate treatment.

I feel frustrated as dialogue and education fall on the deaf ears of my entrenched colleagues. Individual programs and state methadone regulatory agencies must be taken to task for their failure to meet the needs of their patients. Regulations that handcuff reasonable treatment providers ensure that patients will continue to suffer at the hands of politicians and ignorant treatment providers.

Allow competent, compassionate physicians to treat this disease without the interference of self-serving regulatory bodies whose main task appears to be to restrict access to treatment and to demean those who take this most difficult of first steps towards recovery.

My thirteen years of direct service in MMT have made me understand the difficulty in educating other treatment providers in meeting the needs of their patients. The scientific literature is out there that shows what works—some literature has been out there for thirty years. My experience has shown me an arrogance that fails to yield to scientific evidence. My hope is that repeated attacks on the ignorance of how addiction and treatment work will instill a consumer-driven approach to assist the patient in making his life more manageable.

Funding of more treatment slots is critical. Many patients are prematurely forced out of treatment so that people naive to treatment may be given a chance. All too often as one is helped, another is abandoned. **(Cont. P. 3)**

## Smoking Can Worsen Hepatitis C Liver Damage

*Reprinted from Join Together Online (<http://www.jointogether.org>). Join Together is a project of the Boston University School of Public Health.*

Taiwanese researchers determined that patients infected with the hepatitis C virus (HCV) could be further damaging their livers if they smoke, Reuters reported April 10.

For the study, researchers used the protein enzyme ALT to evaluate liver damage in 6,095 men and women living in an area in Taiwan known for having high rates of HCV and hepatitis B virus (HBV). Participants also completed a survey about their drinking and smoking history.

The study found that 31 percent of the study participants with HCV and 11 percent with HBV had high levels of the liver enzyme, while 4 percent of the participants were free of either infection had elevated ALT levels.

The researchers determined that participants with HCV who either smoked or consumed alcohol almost doubled their risk of having high ALT levels. Furthermore, those who smoked a pack or more of cigarettes a day and frequently drank alcohol were seven times more likely to have elevated ALT levels than those who did not drink or smoke. No association was found in patients with HBV.

Study lead author Dr. Chong-Shan Wang, of the A-Lein Community Health Center in Kaohsiung County, strongly advised patients infected with HCV "not to smoke and drink alcohol to reduce the possible risk for aggravating their liver dysfunction."

About 4 million people in the United States and 150 million worldwide have HCV, an infection of the liver that is spread by contact with blood and other body fluids.

The study is published in the April 8, 2002 issue of the Archives of Internal Medicine.

## Dear Methadone Today,



I was recently in a car accident at work. I was just about to use the work van. To make a long story short, I got hurt pretty badly. The rescue was called. They asked me if I was on any medication, but of course I couldn't tell them that I was on methadone, as my co-workers were standing there. When I got to the emergency room, I was asked a second time if I was on any medications, and again I said "none".

I did not inform them that I am on methadone for two reasons: first, I am a consultant at that emergency room as a psychiatric nurse, and I know all the doctors and nurses there, and second, I knew that if I said I was on methadone, I wouldn't get any pain medication, and I was in serious pain. The doctor gave me a shot of Demerol and a prescription for 15 Percocet. I took them as prescribed, and I didn't abuse them at all.

Anyway, I went to my primary care doctor for a follow up

and to get my stitches out. He does know I am on methadone, not because I told him but because the clinic I am on makes us sign a release and write the doctors telling them they have a patient on methadone. They said this is a federal regulation to make sure there are no adverse reactions if the doctor prescribes certain medications. Well, I hadn't been to him since he got that notice. He treated me not that greatly.

First of all, I am getting bad headaches from the accident, and my back and neck are still killing me. He wouldn't give me anything for pain—he merely told me to take Motrin. I told him that the whole right side of my face was numb and that the emergency room doctor said I could have severed some facial nerves. His only response was, "Don't worry about it." He took out my stitches, but he didn't check out my pupils, back, neck, NOTHING. I sometimes see white flashes in my right eye since the accident. Again he said, "Don't worry about it." I asked him if he wanted me to come back again, and he replied that I don't have to. **(Cont. p. 2)**

**Dear Methadone Today (from p. 1).**

I am really angry—I believe he treated me in this manner because he knows I am on methadone and am an addict. I am not going to be treated in this manner. I am going to find a new doctor and quickly. I just wish I knew in advance which doctors were cool with methadone and which weren't. I don't live in the same area as the clinic.

Thank you for letting me let off some steam.

-Sandy

Dear Sandy,

If you have been reading *Methadone Today* for a long time, you know that this type of treatment by physicians is not uncommon. We believe that you are doing exactly the right thing looking for another doctor.

We have never heard of a federal regulation that requires methadone treatment providers to inform all your doctors regarding your methadone treatment. Such a requirement is nowhere in the federal regulations covering the provision of methadone treatment. It is possible that they are referring to state regulations, but we are very skeptical of the clinic's claims.

More likely it is their policy, but in that case they have little means of enforcing it. What would happen if you just did not tell them about some physicians you go to? The only time this would be an issue is if the physician in question is prescribing a medication that would be tested for by the clinic.

In any event, we strongly disagree with such a policy. We feel that your clinic's policy interferes with patient confidentiality. Furthermore, the clinic needs to recognize that much discrimination exists within the medical community. Doesn't methadone clinic staff understand that most methadone patients would very much like to be able to tell their physicians about being on methadone maintenance, and still receive respectful, quality care? How many patients have finally found a physician that they like and are afraid to inform them of their methadone treatment participation, lest they be rejected or mistreated by that physician? Of course, the ideal situation is to find a physician whom you can inform about methadone treatment and your addiction history and who will still provide courteous and high quality treatment, but in reality this is not always possible.

Whatever you decide, we think that you need to get treatment for your current medical problems elsewhere. You should not have to suffer in pain, and this potential nerve problem needs to be addressed as soon as possible. We discussed finding the right physician in the May 2002 issue ("Your Other Doctors, p. 1). If you are friends with another methadone patient or are aware of a local patient advocate/advocacy group, we suggest you consult with them in the event they know a good area physician.

Thank you for writing us with your concerns, and we wish you luck finding a physician.

## Urine Testing in MMT: Poor Clinical Correlation

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

*\*Fellous J, Lowenstein W, Gourarier L, Bonan B, et al. Relevance of urinalysis monitoring of methadone maintenance patients: a clinical-biological agreement on 41 patients. Addiction Biology (2000) 5:313-318.*

This interesting report from a Paris addiction treatment service tells us much about good medical treatment with methadone, as well as showing the benefits and limitations of urine drug testing in the clinical environment. These researchers reiterate that urine testing should never be used punitively but more as a clinical guide or reminder. They state that such testing is "still used by some as a disciplinary measure despite recommendations of clinicians and epidemiologists. It should not be performed as a repressive imposition which will probably lead drug abusers to falsify their urine samples" (6 references [citations omitted to save space]).

The study's sub-group of the clinic population comprised 41 long-term methadone maintenance treatment (MMT) patients with mean age 33, 57% male, 92% injectors. Dose ranges were also typical with 90% receiving between 30 and 120mg daily (mean dose 72mg). Five percent were prescribed in excess of 120mg. The overall clinic's annual retention rate appeared to be a staggering 96%.

All patients had at least one test every 2 months during the 12 months of the trial which examined results in comparison with clinical history given to health professionals. The simplified addiction severity measure used self-report of drug use and medical/social consequences. There was a "very poor agreement" with urine test results. The authors conclude that urine test results should be used as a surveillance to alert the physician to early relapse and to schedule earlier consultations for action to be taken, such as dose adjustment, counseling, etc.

This report underlines that urine testing has still not been proven to have any effect on the outcomes of treatment or prevention, despite popular belief of a therapeutic benefit from such surveillance.

Urine testing, as long as it is (1) handled to minimize falsification (i.e., temperature tested); (2) tested by reliable and sensitive methods; and (3) used without any threats of adverse consequences on treatment—is an accurate way of determining a subject's recent intake of drugs. This provides evidence for research into medical, legal or epidemiological aspects of psychoactive drug use. It probably also has a place in improving clinical outcomes, but this remains to be proven by comparative research.

I was intrigued to learn this week that the Australian Health Insurance Commission has increased from 21 to 36 the maximum rebateable number of urine toxicology tests per annum. Why ever would they fund additional tests per year when there is no evidence that they are of any benefit? Could politics have influenced matters?

**Editor's Comments:** Among some U.S. methadone treatment providers, the position that urine tests should not be used for punitive purposes would virtually be regarded as blasphemy. Many clinics will discharge (or as they say, "terminate") patients for positive urine test results, and patients receiving financial assistance with the cost of treatment [from a government entity, a non-profit organization or the treatment provider itself] are often subject to termination for positive urine tests. But this report confirms our firm belief that punishment for illicit/non-prescribed drug use is unethical and does not improve treatment outcomes.

As for the issue of urine sample falsification raised by Dr. Byrne, this would scarcely be a concern if patients did not fear punishment. We do not see anything wrong with inexpensive, non-intrusive methods of preventing falsification (i.e., temperature testing of the sample), but anything more is apt to erode trust. We certainly do not approve of supervised urinalysis of all patients; this is humiliating, a privacy violation and results in problems with some patients being unable to urinate. Supervised testing may be justified in a small number of cases (i.e., where clinic staff has good reason to suspect a patient has tampered with a test in the past). Better yet, use of oral swabs instead of urine testing may remedy these privacy issues.

## Group Wants MMT Patients to use Birth Control

The letter following this article has been circulating on the internet. The organization responsible for the letter is "Children Requiring a Caring Kommunity" (AKA: C.R.A.C.K), and their web address, <http://www.cashforbirthcontrol.com>, says it all. Obviously, sterilization of people addicted to drugs is a highly controversial issue. If an organization is going to rely on such methods, they should at least get their facts right.

The reasoning they use is that abuse of the drugs in question while pregnant may jeopardize the fetus. It is well established that using certain drugs, including alcohol and tobacco, risks harm to a developing fetus (i.e., fetal alcohol syndrome). However, they are deeply mistaken when they lump medical use of methadone in this category.

As has been published in previous issues of **Methadone Today** (most recently, "Methadone & Women," p. 1, April 2002), a maintenance dose of methadone is **not** harmful to the fetus. The probability of various defects or complications is no greater for infants born to methadone maintained mothers. In fact, maintenance is the recommended course of action for the opiate dependent pregnant patient. Withdrawal is considered risky to fetal development.

Thus, it is tremendously irresponsible for this organization to make such claims without at least researching the medical issue. Contrary to their statements, being on methadone maintenance is not a compelling reason to refrain from getting pregnant. We also do not appreciate the implication that that methadone patients are "addicted" to methadone. They may be dependent, but addiction implies a whole set of behaviors that are not present when taking this medication properly.

Perhaps most shocking of all is that there are methadone clinics involved. Certainly, methadone treatment providers ought to be educated regarding pregnancy and methadone maintenance treatment. We advise our readers to be suspicious of any methadone treatment provider who is involved or associated with this organization.

We apologize to those readers who are offended by the letter. But we feel it is important that this be publicized, lest this organization continue to spread misinformation.

[Letter from C.R.A.C.K. Follows]

To Whom It May Concern:

Our organization offers cash incentives to both men and women that are addicted to drugs and/or alcohol to use long-term or permanent birth control.

**We are currently working with several methadone clinics that make our offer known, and available to the women and men who come through their program.**

I'm sure one thing most can agree on is that it is important for those using methadone or other drugs to refrain from getting pregnant.

Please call (888)

30-CRACK if you would like more information, or more of the items that have been enclosed.

Our program is currently in over 20 cities nationwide, and has paid over 600 men and women to obtain long-term birth control. Thank you for the time, and we hope to establish a working relationship with you, for both the benefit of the woman, and potential child.



Sincerely,

Barbara Harris, Founder and Director  
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**Editor's Note:** *We have included contact information so that you may write this organization to let Ms. Harris know that we certainly do not agree with her assessment regarding methadone and birth control.*

### Scattered Thoughts (from p. 1).

. Many patients may not be able to afford private treatment and depend on state funded slots to receive methadone treatment. Waiting lists were many months long when I started in this field and no significant improvement has occurred.

Dose limits need to be eliminated. The original research done on methadone by Dole and Nyswander suggests that average doses need to be 80 - 120 mg. It is my unfortunate experience that many clinics erroneously consider this as an upper limit or proudly state that they have no dose limits but also have no patients that require more than 100 or 200 mg. Even though federal regulations now have no limit on doses, many states and individual clinics continue to be mired in 19th century

thinking that methadone is a toxin and the sooner one is detoxified the better. The idea that methadone is an effective medicine seems beyond their grasp.

The intrusiveness and high error rates of urine tests need to be re-examined as a basis for privileges. Urine testing should only be done at the patient's request to demonstrate their progress in treatment rather than enforcing an arbitrary number of tests. Urine testing in treatment should be for therapeutic, not punitive, reasons.

I'm sure that there is room for dissent among treatment providers, but I cannot agree to be tolerant of prejudice, stigmatization, or inflexibility. These attitudes harm my patients by fostering a shameful attitude towards recovery.

The forced withdrawal from methadone as ordered by probation and parole officers, child welfare caseworkers, and primary and emergency care physicians cause patients to question a therapy that has significant benefits for them and to prematurely leave treatment. These professionals are practicing medicine without a license, and those who are physicians are giving less than the best practices to which they should be ascribing.

Diabetes is also a chronic disease with various treatment options. Some are able to control their illness with diet, while others need daily medication in order to survive. It is rare that someone who progresses to needing medication to control their diabetes is able to return to only using diet to manage their illness.

Some opiate dependent persons are able to control their disease with "diet": they eat from the 12-step plate, they eat from the psychotherapy plate, they eat from the abstinence plate, they eat from the "cold turkey" plate. Others will need medication to assist them in controlling this disease, and the proven medicine is methadone. It is my experience that many patients on opiate agonist therapy will not be able to return to being able to control this disease with "diet" but will have lifetime medication requirements. It is more realistic to view withdrawal as finding one's lowest stable dose, which everyone wishes to be zero but will probably not be zero. Patients will still go to zero to avoid stigmatization, poor treatment, or ill-informed outside pressure. But they place themselves at risk for all of the related woes of relapse or at the least the feeling that there is a missing piece of the puzzle that gives one a feeling of normalcy.

Thank you for allowing me to submit these remarks.

# RI SMA Official to Receive Congressional Citation of Recognition

by B. Miller

*Rhode Island* - Craig Stenning, the Executive Director of the Division of Behavioral Healthcare Services within the Rhode Island Department of Mental Health, Retardation and Hospitals, will be presented with an award July 29<sup>th</sup> by Congressman James Angevin in recognition of his outstanding and pioneering work involving Rhode Island's methadone withdrawal protocol within the RI Department of Corrections. Rhode Island is the second state to provide methadone treatment to all inmates. New York's Rikers Island is the other, though Rhode Island is the only state to offer it statewide to all opiate addicted inmates in the correctional system.

When Mr. Stenning was appointed Executive Director in 2000, he was one of the first State officials in the country at this high level with an extensive background in methadone treatment. Mr. Stenning not only worked closely with officials within the RI Department of Corrections on this project but also deserves to be recognized for the work he does everyday and his unselfish dedication to enriching the lives of others. He has been a strong advocate for comprehensive program standards.

Of special note, he has vocally supported the necessity of listening to the voices of patient advocates and people in recovery. He insisted that patients be included in the focus groups he conducted when he began his new job. He was also successful in adding consumers to the peer review process in all treatment agencies, and new licensing standards will insist that patients and family members be included on Boards of Directors.

Mr. Stenning is a fair person with undeniable integrity that is apparent through the decisions he makes which benefit all MMT providers and patients. Recently, the Division began a major overhaul of the method in which state supported methadone slots are distributed in order to improve access. This follows RI's completion of new Narcotic Treatment Provider (NTP) regulations that complement recent federal changes. Under his direction, RI sponsored the First Annual New England Conference on Best Practices in Opioid Treatment, which has transformed this year into the First New England School of Opioid Treatment.

When I asked Mark Parrino of the American Association for the Treatment of Opioid Dependence (AATOD) to write a letter of recommendation for Craig Stenning, he did not hesitate. Here is an excerpt from that letter: "I can tell you that Mr. Stenning has been one of the most visionary and committed treatment providers in the United States prior to his appointment in the State of Rhode Island. He served more than 25 years as the Executive Director of CODAC, which is one of the largest multi-service substance abuse treatment

facilities in the New England area. He was also the recipient of the prestigious Nyswander-Dole Award, which is given to individuals who have met the highest standards of providing excellent care for methadone treatment services in the U.S. He received this award at the NY Conference in 1988. Aside from this, I can tell you that I have extraordinary respect for Mr. Stenning and his capabilities. I find him to be one of the very best people I have met in this field, and I have met thousands." Of special note, when he was at CODAC, Mr. Stenning spearheaded a national effort to examine staff attitudes towards methadone patients, drug users and methadone treatment. He continues to strongly advocate for close scrutiny of staff attitudes and their effects on program policies and patient rights.

After founding CODAC in 1971, Mr. Stenning initiated the first short-term methadone detoxification program in RI. Then in 1975, CODAC took over a very small state-run methadone clinic and developed it into a statewide network of three sites and over 1,200 patients. CODAC was the only methadone program in RI to be accredited by JCAHO, having received accreditation with commendation in both of its surveys. He co-chaired the National Methadone Conference when it was held in RI and for many years co-chaired the American Methadone Treatment Association (now AATOD) International Committee.

Any comments, questions or congratulations should be directed to [Cstenning@mhrh.state.ri.us](mailto:Cstenning@mhrh.state.ri.us).

**Editor's Comments:** We congratulate Mr. Stenning on his achievements. It is good to see that there are public officials working to improve the quality and accessibility of methadone treatment. Furthermore, we would like to see prisons in other states follow Rhode Island's lead in making methadone treatment available to ALL opiate addicted inmates.

Groups such as **DON'T** (Detroit Organizational Needs in Treatment) and **ARM** (Advocates for Recovery through Medicine), which advocate for opiate agonist/methadone treatment should not only speak out critically of policy makers who perpetuate the negative myths regarding methadone treatment and who propose bad laws, but should also praise policy makers who have made a positive impact.

***\*Is there a state or local representative/policymaker in your area who has made positive efforts in the area of addiction treatment in general or opiate agonist/methadone treatment specifically? Methadone Today would like to hear from you about it. Contact us at the P.O. box or e-mail address listed below. In fact, we are very interested in publishing any readers' comments, stories or articles--please send us your material!***

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DON'T is a non-profit 501(c)3 organization dedicated to helping patients achieve quality methadone treatment, preserve patient dignity, provide greater public understanding, eliminate discrimination toward methadone patients, and promotion of harm reduction policies.

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