

Methadone Today

The official newsletter of DONT--by patients, for patients November 2002 Volume VII Number VIII

Keep an Open Mind: Methadone Saved My Mom

The following pertains to last month's issue of *Methadone Today* (September/October 2002) about local opposition to the opening of a methadone clinic in Johnson City, Tennessee. The letter below was written to a member of the Tennessee House of Representatives, David Davis.

This is, in fact, a good example of a letter to a representative/policymaker, though in many cases, depending upon what you want from the individual, the concluding paragraph would explicitly state what the writer wants him/her to do (i.e., "...Therefore, I urge you to vote yes on bill X.").

Dear Representative Davis,

I would like to introduce myself. My name is Andria; I am 19 years old. I do not live in your area; in fact I live far away from you, but I just wanted to tell you what I have learned about methadone over the past few years. I read the article in the *Johnson City Press* about the methadone clinic that nobody wants and about that mother that had her 29-year-old daughter die because she had methadone in her system.

Because of methadone, my mother lives, and not only does she live, she is a mother again. My sister and father and I lost her to a severe opiate addiction. It was off and on since I was 6 years old, but it got real bad a few years back when she had a bad accident and had to go on pain medication. Her addiction to opiates got so bad that she would be out all day and all night trying to get high. She missed most of my important teenage events, and when she was home, she was barely functioning. Alcoholism and drug dependency run in her family, and it was very obvious that this was not something she wanted to be doing but rather something she had to do.

When her problem got to its worst, someone recommended that she go on methadone. At first we were all very taken back by it. We thought the same things about methadone that (**Cont. p. 3**)

Portland, Maine, Moving to Provide Anti-Overdose Drug to Addicts, EMTs

Reprinted from DRCNet Issue #247

(Visit the DRCNet website at <http://www.drcnet.org>)

Faced with a rising number of overdose deaths, officials in Portland, Maine, are moving forward with plans to increase the availability of Naloxone, a drug administered to overdosing heroin users. According to a report in the *Portland Press Herald*, police, fire and public health officials met on July 17 to find ways to blunt the increase in overdose deaths, which rose from 16 in 2001 to 20 so far this year.

Local officials plan to offer naloxone to addicts who participate in the city's India Street Clinic needle exchange program, the newspaper reported. Under the plan, participants would have to undergo training in how to properly administer the drug, then they would be provided with a kit that includes a dose of

Nicole's Story: Giving Birth While on MMT

*Reprinted from Addiction Treatment Watchdog
(<http://www.atwatchdog.org>).*

Thanks to ATWatchdog for their efforts to educate patients and expose abuse by opiate agonist treatment providers.

My water broke two a.m. Saturday morning, November 24th. I went across the street to L&D Hospital (the hospital is across the street from my parent's house). I took my methadone folder with me.

I got there around 3 a.m. It appeared the baby may be breech, so two ultrasounds and two x-rays later, they schedule me for a C-section. The anesthesiologist comes in early to discuss pain management and such and the drugs he will be using during surgery. He is going to do a spinal block rather than an epidural, and use 15 mg of morphine every three hours post surgery rather than Dura-Morph in the spinal because they use Nubain or Narcan to control the side effects of Dura-Morph, which I can not have. Now by this time, they have pumped four 1000 ml bags to me.

Surgery goes well. My daughter is born at 8:18--they had a full neonate team ready in case there were problems. All went well. After I got to hold her, they took her with my dad to the nursery. I had to stay and finish up, then problems started. I started to feel pain, so they knocked me out with a sedative. In recovery, I started in with withdrawals, despite a fair amount of morphine on board. So an RN sat with me and helped restrain me at times during spasms. They dosed me with my normal dose of methadone, as well as morphine.

I was given really good pain relievers to keep the pain at bay the first two days. I was given my methadone; 100 mg in the a.m. and then 15 mg of morphine every three hours and 25 mg of Phenergan every 6 hours. Then they switched me to 2 mg Dilaudid every three hours and my normal methadone dose every day. Until last night when I got to come home, (**Cont. p. 3**)

naloxone, latex gloves and alcohol wipes. Drug users would also be encouraged to call 911 to report overdoses, because naloxone's opiate-blocking effects are only temporary. The local police chief has said he will not "subvert criminal investigations" if confronted by an overdose, but would take all factors into account because "after all, we're trying to save lives."

The plan will also extend Naloxone availability to all 52 of the city's ambulances and fire trucks. Currently, only 30 paramedics are authorized to stock the anti-overdose drug, but city officials are working to win state approval for Emergency Medical Technicians (EMTs) as well as paramedics to administer the drug.

Citing efforts in Chicago, San Francisco, New Mexico, Germany and Australia, Portland officials embraced harm reduction principles in dealing with the rising death toll. "We're focusing on the problem as a public health issue rather than a criminal issue," Portland Director of Health and Human Services (**Cont. p. 2**)

Portland to Provide Anti-Overdose Drug (from p. 1).

Gerald Cayer told the Press Herald. "Our short-term goal is to reduce mortality. Our long-term goal is to reduce opiate use."

Portland officials said they hope to have the program in place by September.

Editor's Note: How to mitigate harm associated with opiate abuse is an important issue. For this reason, we elected to print this even though it is not directly related to opiate agonist treatment. We praise Portland officials for developing a sensible plan to reduce overdose deaths. Education could also save many lives--friends and family often do not know what to do in the event of an overdose.

Dosing in Pharmacies: A Feasible Alternative

by Dr. Andrew Byrne, General Practitioner (NSW, Australia)

**Luger L, Bathia N, Alcorn R, Power R. Involvement of community pharmacists in the care of drug misusers: pharmacy-based supervision of methadone consumption. International Journal of Drug Policy (2000) 11:227-234.*

This paper proves to the skeptical in the US and UK that supervision of methadone doses can be done in existing community pharmacies. In Australia it has been done for over 30 years. The authors found that community pharmacies were generally prepared to witness dosing of dependency cases. Many pharmacists had previously felt ill-prepared for dealing with aggression, shop-stealing and intoxication. After a one-day course, 17 pharmacists took on 79 patients (mean 5 patients each) for a period of up to 9 months. Two-thirds reported that they found it satisfying work. Four General Practitioners (GP) were recruited to prescribe for stable patients chosen under certain criteria. These seemed rather less rigid than the new US requirements for "medical maintenance" but were not stated specifically. Perhaps for this reason, 34 of the 79 patients dropped out in the study period. An apparent average of between 3 and 4 doses per week were supervised with almost 3000 supervised doses in these patients over the study period. Dose levels are not stated, but a previous report from a sub-group of this treatment service quoted 43 mg daily as a mean dose (Curran et al 1999). In addition, the use of intercurrent drug use in this report was substantial perhaps as a result of inadequate dose levels.

The literature on pharmacy dispensing is slowly catching up with the implementation of this modality, which began in the 1960s in some areas but has still not been used in most American states. Despite being the most widespread form of methadone dispensing in many areas, there is almost no rigorous comparative research. In two Australian states (Vic, Qld) it is virtually the only means of access for very large numbers of dependent patients. The same is true of much of the UK but without supervision and with substantially more public sector support from multi-disciplinary specialist dependency services attached to area health services.

A number of issues remain problematic according to patient surveys. These include privacy and interaction with other customers. A retail pharmacy with enough 'investment' in dependency treatment might find it worthwhile to use a small cubicle like a voting booth or just a small partition. One pharmacy in this study had taken such steps. My own local pharmacy has a security video camera, and this has detected at least one patient trying to divert his dose 'for a friend who was on the waiting list for treatment'. [Note: the camera was not installed for drug patients, but for general security.]

Even though there is no formal requirement for pharmacists to supervise the dosing of medication, it is something that they have done in some jurisdictions for over 20 years without problem. Most pharmacists are committed professionals who will be involved with the medical profession in treating dependency and pain management patients. Strict daily dosing can be onerous and is rarely necessary for any length of time as long as patients achieve stability. Two to three supervised attendances weekly may be necessary to ensure adequate safety and effectiveness, even for a majority of stabilized cases. There is also a political imperative to demonstrate to the wider community that this treatment is rigorous not subject to abuse.

In order to make pharmacy dosing satisfactory, we need to avoid the related problems of (1) a lack of privacy and of (2) patients feeling that they are being kept waiting until others have been served. We also need to carefully define stability in terms that can be used by GPs. Ezard's survey in Melbourne also found widespread complaints of a lack of confidentiality, long waiting times and unsuitable opening hours. They also found a proportion of patients reported pharmacy dosing to be highly satisfactory. Pharmacists report a lack of support from some doctors as well as difficulties with how to deal with intoxicated and demanding patients. Nausea and vomiting can also be practical problems which are hard to deal with outside the clinic setting. As with other prescribing, the doctor's instructions should be clear and unambiguous regarding all aspects of the treatment, including the number of supervised doses in a given period.

Early morning dosing is essential for some patients, especially for young, unskilled males whose laboring jobs often start before pharmacies open for trading. While afternoon and evening dosing hours suit some patients, they are unsatisfactory for many new and unstable addicts, especially those who are paid in cash at the end of a working day. They may yield to temptation, and thus sabotage work for the following day unless an early dispensary can be used.

There would be a market for a pharmacy near transport which opened around 6 a.m., even on just some days of the week. This would cater to a very important market, both for workers and some mothers with young children. I know of one such example in Sydney's far west where a chemist shop opens at 5.30 a.m. on Monday, Wednesday and Friday, which is a boon to local patients.

We need to use pharmacies for settled patients, but we must avoid sending difficult, unstable people to ill-equipped high-street chemist shops where they can upset things and spoil it for everyone else.

Methadone Saved My Mom (from p. 1). most of you that are opposed to it do—that it was no good and it would just cause more problems. But because we love our mother so much, we all decided to support her decision. We read as much information about it that we could. And what we found out is that when a person chooses to go on methadone, what they are really saying to themselves, their family and society is that they are ready to give up ever getting high again and that they are ready to live a normal life.

When a person takes methadone, they get to a "blocking dose", and once they have reached that "blocking dose" their brain and body shut off the signals to "get high". They could take huge amounts of drugs and not feel the euphoric effect that drug abusers seek. They also stop "craving" opiates. What methadone has done for me, my sister, my father and most of all my mom is given us our mom back. We now have the family life that I wanted so bad when I was in school. I just can't understand why you or anyone else would want to prevent any other children from having the same opportunity as we have had.

I realize people are scared of it because they don't understand what it is really meant to do. And I know that there are many people out there that even abuse methadone, like those people that were at that motel and gave that girl methadone, probably for the first time. When taken as prescribed, you have to go on it gradually; you can't just take a large amount at once because just like any other medicine, you could die. I am so sorry for that girl and especially her mother. I wish I could give the mom a big hug, but being a mom herself, then she could understand how happy I am to have my mom with me.

Please do not be "closed minded" about this subject. It could save hundreds of lives if it is taken correctly. It did mine and my moms. Thank you for listening. Sincerely,
A. K.

Giving Birth While on MMT (from p. 1). then I was given Dilaudid every four hours for four days, and I am supposed to call him if I am still not up to snuff.

The OB had left a packet of methadone info at the nurses station so that the nurses would know what to watch for and to learn a little bit. It was great. Everyone was positive; they asked intelligent, professional questions. I could not have asked for better care.

My daughter was born at 8:18 a.m., Saturday, November 24, 2001. She

weighed 6 pounds, 8 ounces, 18 1/4 inches long. She was three weeks early.

She nursed three hours post surgery, and roomed in with me. She was showing signs of withdrawal, although mild, about four hours after birth, but they caught it very early. Her moro reflex, her startle reflex were both hypersensitive. She was starting to sneeze and had a runny nose. She was started on .02 mg paregoric every three hours, round the clock.

She is doing great, nursing, and getting well. We were in the hospital until last night around 6 p.m. They kept us an extra day and a half because her bilirubin level was way up, and she had to be kept under the ultraviolet lights in the isolette for four hours. It went down enough for us to safely come home. She goes to the doctor tomorrow to make sure that she is stable on the dose, as they need her stable for a week before they can begin to decrease. It is a very slow decrease.

The nursery staff were absolutely awesome. When I was rocking outside of her isolette, a couple of the RNs came up and said that they voted me the best Mom of the Year, for all I had overcome and what a wonderful gift I had given my daughter. That was very special to me. They really wanted to learn about methadone and wanted to hear my story. They got tons of literature that I gave out, and then they were able to access stuff that I had not seen on some of the medical web sites. I did not hear one negative comment, and I got a ton of positive comments.



Editor's Note: Giving birth is always a painful, stressful experience, but this is an example of how high quality medical care by informed medical personnel can minimize stress, discomfort and complications for the mother and especially the infant. In spite of a complicated birth, requiring a C-section, the

hospital did a good job managing the mother's pain, and promptly detected and treated the newborn's withdrawal symptoms (many babies born to methadone patients never experience withdrawal symptoms).

The Benefits of Pharmacies (from p. 4).

Patients with private health insurance may also benefit financially by obtaining their medication from a pharmacy instead of their treatment provider. For



instance, in many cases where the insurance company will not cover the treatment itself, they would cover the cost of the medication if it were obtained from a pharmacy. The reason for this is that many policies exclude medications actually dispensed by the treatment provider from their "prescription drug benefits."

Finally, the utilization of pharmacies would make it easier for treatment providers to handle emergency situations. In other words, how would patients be dosed if the treatment facility were unusable due to electrical outage, disruption of water service due to a water main break or plumbing problem, damage to the building by fire or natural disaster, or impassible roads as a result of snow or ice.

The majority of treatment providers still appear to be poorly prepared for such emergencies, and prior arrangements with local pharmacies would seem a prudent precaution. Since currently, pharmacies do not provide methadone for opiate agonist treatment, they would not have nearly enough medication to dose patients in an emergency, even if they were permitted to do so. Pharmacies do fill prescriptions for methadone when prescribed for pain management purposes, but they are likely to only have a small quantity in stock.

Pharmacy dispensing of medication would be a useful option to many patients. There is no reason this option should not be available to stable patients who are already entrusted with take-home doses. The purpose of opiate agonist treatment is to restore function and normalize the patient's life--the ability to obtain medication from a pharmacy would allow the patient to lead a more normal life.

The Benefits to Dosing in Pharmacies

The utilization of pharmacies in methadone maintenance treatment would provide benefits to both patients and treatment providers. A recent study found that pharmacy dispensing is a practical method of dosing methadone patients (see page 2, "Dosing in Pharmacies: A Feasible Alternative"). There are several scenarios where dosing and obtaining take-homes would be preferable to going to the methadone clinic to dose.

To begin with, at many clinics, patients have to wait a long time just to dose and obtain take-homes. Oftentimes, clinics will only dose patients who are employed during certain early morning hours so that there will be less waiting during this period, enabling those patients to get to work on-time. Such measures certainly help, but they do not solve the problem. Patients may still have to wait a fairly long time to be dosed, and this is inconvenient, even if it does not actually interfere with employment.

In some cases, patients can lessen their wait by coming at a different time, but at clinics with very limited operating hours, there really is no other time, and there is not always room in a patient's schedule to do this. Some patients may also have unpredictable hours, so if they do not dose in the morning, they may not finish work until the clinic is closed.

Dosing at pharmacies could potentially solve many of the aforementioned problems. At least in the case of large metropolitan areas, pharmacies tend to have longer operating hours than most methadone clinics. Virtually no methadone clinics remain open past 7:00 p.m., and in many areas, the clinics have very limited or non-existent afternoon hours. Pharmacies willing to serve methadone patients may not provide this service at all hours that they are open (i.e., there are 24 hour pharmacies that may not want to handle supervised dosing, in the middle of the night), but the hours are still likely to be longer and more flexible than that of the typical methadone clinic. Some methadone patients may be willing to pay a small additional fee so that they can dose at a time that most methadone clinics are closed (i.e., 7 p.m. and after). Under the current setup, the patient does not have this option and may have to miss a dose if they are unable to get to the clinic during its normal hours, as a methadone clinic is not going to agree to remain open--even if the patient is willing to pay extra for it. Similarly, the wait at a pharmacy is likely to be shorter than at many methadone clinics, especially during peak hours.

In addition, there is the issue of location. Some methadone patients do not have a methadone clinic near their home. Other patients may live relatively close to their clinic but work further away, so if for some reason they wanted or needed to dose during lunch, they would not have enough time to drive to the

clinic and back to the workplace. But if pharmacies were able to dose patients, such patients would be able to dose at a pharmacy near their home or workplace.

Obviously, patients would still have to go to the treatment facility/clinic for periodic counseling sessions and doctor's appointments and possibly to submit urine samples. In some countries, pharmacies also handle urine sample collection and pass the sample on to the lab to be analyzed.

Patients may decide that dosing at their clinic is more convenient than going to a pharmacy--at least on some days. Among the obvious advantages to dosing at the clinic is on days that they must attend the clinic anyway for a counseling session or doctor's appointment. They would only have to make one trip to the clinic instead of two--one to the clinic and one to the pharmacy. But it would be nice to have a choice of where to dose; besides, permitting pharmacies to dose patients is likely to decrease the wait to dose at clinics since less total patients would be dosing there.

Pharmacies would be of particular use when dosing patients receiving extended take-home supplies (14-30 days). To begin with, there would be less problems associated with supervision and privacy, since supervised ingestion is not required by the federal regulations in such cases. In other words, the patients would not have to ingest a dose at the pharmacy while a pharmacist watches--the prescription could be filled and dispensed more or less like any other prescription is filled and dispensed. Utilization of pharmacies would allow for more flexibility for such patients. If some unforeseen event forces the patient to reschedule a clinic doctor's appointment, the physician could prescribe a few days' worth of medication to be filled at the pharmacy so that the patient will not run out before the appointment. In such instances, the option of picking up the medication from a pharmacy that is open on Sundays and holidays would mean the difference between dosing or not--and perhaps relapsing or not. . (Cont. p. 3)

Correction:

In the article, "Not In My Backyard"--Opposition to Opening A Methadone Clinic Led By Grieving Mother," on page 1 of the October 2002 issue, we stated that, "there is currently only one methadone clinic in the entire state of Tennessee." This statement is incorrect--there are currently five methadone clinics in Tennessee, not including the proposed Johnson City clinic, which has not opened--at least, yet. Nonetheless, we still maintain that additional methadone clinics are sorely needed in Tennessee.

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