

# Methadone Today

The official newsletter of DON'T--BY PATIENTS, FOR PATIENTS October 2004 Volume IX Number VII

## ANNOUNCEMENT:

The following is a special issue--published jointly by DONT and Advocates for Recovery through Medicine (ARM). ARM is a 501(c)(3) non-profit organization devoted to education and advocacy of opiate agonist therapies (i.e., methadone, buprenorphine and others that may come along). ARM was created five years ago by many long-time advocates and consumers who saw the need for a national organization to support their needs and requests for assistance in the educational/media/political arenas.

Part of this issue highlights the various conferences that ARM representatives and chapters have attended and participated in. Anyone who would like more information about ARM or who wish to become an ARM member or volunteer, may contact ARM at the address listed at the bottom of page 4 or email [DCReardon@aol.com](mailto:DCReardon@aol.com).

## ARM Chapter News by Chris Kelly (ARM-DC)

**ARM-CT** – George Clarke, Director, was a featured speaker at the **2004 Leadership Conference** sponsored by Advocacy Unlimited. George talked about the concept of Dual Diagnosis Friendly and Methadone Maintenance Friendly in relation to 12-step organizations. ARM-CT has also been working with the CT Department of Corrections to get both buprenorphine and methadone maintenance and taper into State jails and prisons.

**ARM-DC** – Chris Kelly, Director, appeared in the **SAMHSA Recovery Month Webcast "Addiction By Prescription" together with Mr. Curie, Director of SAMHSA, and Dr. Nora Volkov, Director of NIDA**. The webcast can be viewed at <http://www.recoverymonth.gov/2004/multimedia>. Ms. Kelly is also a member of CSAT's Expert Panel on Co-Occurring Disorders, Drug Interactions and Emerging Issues in Opioid Treatment. Ms. Kelly will be speaking at the Recovery Ambassadors training in San Francisco in October. More information about the Recovery Ambassadors can be found at (**Cont p. 3**)

## Report on Leadership Conference by George K. Clarke (ARM-CT)

The 2004 Leadership Conference sponsored by Advocacy Unlimited and held at the CT State Office Building was attended by about 100 persons. The Keynote speaker was David Wertheimer, M.Div., M.S.W. from Seattle, WA. He shared his well-known presentation, "Why We Need To Make Noise about Co-occurring Disorders."

This presentation concerned the ways dual diagnosis treatment has been pursued. (*Editor's Note: the term 'dual diagnosis' is used to refer to the diagnosis of both drug addiction and mental illness in a given patient.*)

- 1) No Treatment at all
- 2) Treatment of either addiction or the mental health issue
- 3) Treatment of both separately.
- 4) Treatment of both together.

His presentation showed that about 5% would recover with no treatment at all. If item 2 and 3 were offered, about 5% would recover. Treatment of both together resulted in 15% and a cumulative basis year after year.

So, the obvious best platform was to treat both together.

The first Panel concerned a large group of professionals, advocates and family members.

The second panel involved five people: one from AA, one from NA (Narcotics Anonymous), one from Double Trouble, George Clarke from ARM [and also DDF (Dual Diagnosis Friendly) and MMF (Methadone Maintenance Friendly)], and one patient.

Each was allotted a short time to tell them about their organizations or memberships.

I brought up the problems I had trying to introduce the concept of Dual Diagnosis Friendly and Methadone Maintenance Friendly into a 'twelve step' organization (\*AA and NA are examples of twelve step organizations). The "Friendly" concept (**Cont. p. 4**)

Dear Methadone Today,



My name is Graham and I found your website doing a search on "methadone and being drug tested at work". I was trying to find out if a generic opiate/PCP/cocaine/THC/benzo drug test will give a positive if you are on methadone.

I see a pain doctor, and he has me on 80 mg Oxycontin and roxicodone 30 mg for breakthrough pain. I just started a really great job--but after taking the drug test, coming up positive for opiates and giving them the pharmacy printout, I was told that I could not work for them, due to workers compensation failing to cover me! Which really seems like discrimination. It isn't like I am nodding out at work or anything--I actually don't feel any euphoria anymore from being on it for so long.

My doctor is willing to put me on methadone for long-acting pain in place of Oxycontin and possibly Dilaudid for

breakthrough. I will try to just take the methadone due to failing the test if I don't. But after I take the initial test, I can take my breakthrough medications. I am wondering what dose to be put on? I am shooting for like 100-150 mg a day? Does that seem right?

Also, are you sure it doesn't show as an opiate on drug tests? I just need to be certain that I do not test positive and lose this opportunity. **-Graham**

Dear Graham,

It is true that methadone does not show up as an opiate on drug screens. Methadone would have to be specifically tested for in order to be detected by a drug screen. The standard drug screen does not test for methadone, but an employer may request that methadone also be tested for. At some point, you might be presented with a form that lists the types of drugs that will be tested for--then you will know for sure whether they will test for methadone. (**Cont p. 2**)

**Dear Graham (from p. 1).**

Some medical clinics will ask you for a list of prescription drugs up front--or ask for a list of prescription drugs if you test positive for one or more drugs being screened, and then will only tell the employer about positive test results that are NOT the result of legitimate prescription drug usage. Unfortunately, the majority of these clinics elect to simply give the 'raw' test results to the employer, and leave it to you to explain to them that the positive test results are due to the use of prescribed medications.

So, if you switch from Oxycontin, etc. to just methadone, at least until you have taken the pre-employment drug screen, you are less likely to have a problem with the drug screen but, you could still run into a similar problem if the employer does decide to specifically test for methadone.

Regarding the job that you were let go from because you tested positive for opiates, you should consider consulting an attorney with experience representing employees in ADA (Americans with Disabilities Act) cases. That employer may have violated the ADA by firing/refusing to hire you because you are taking legitimately prescribed opiate medications for the treatment of chronic pain. This case is a little bit different than what we are used to--we have corresponded with methadone patients prescribed methadone for the treatment of opiate addiction--as opposed to chronic pain patients. Drug addiction is considered a 'disability' for purposes of the ADA\*, so methadone patients are covered by the Act. You may also be covered under the ADA and have a case against this employer, but an experienced attorney needs to make that determination. For your information, this employer's excuse about "workers compensation failing to cover" you is most likely complete nonsense.

Finally, we are not sure what dosage of methadone you will need for adequate pain relief. Your doctor should have a very rough idea of the proper dosage based on the short-acting opiate medications you are currently taking. Even so, your doctor will probably have to start you on a lower dosage of methadone and then raise the dose until it adequately manages your pain. And as your doctor indicated, you may sometimes still need short-acting opiates for 'breakthrough pain'.

*\*Note: The ADA does not cover individuals currently using illicit drugs, thus the aforementioned protections only apply to drug addicted individuals who are in treatment or otherwise 'in recovery'.*

## Study Finding: Long Acting Oral Morphine Suitable As Maintenance Medication

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

*\*Slow release oral morphine versus methadone: a crossover comparison of patient outcomes and acceptability as maintenance pharmacotherapies for opioid dependence. Mitchell TB, White JM, Somogyi AA, Bochner F. Addiction (2004) 99: 940-945.*

This study took 18 consenting methadone maintenance (MMT) patients and transferred their treatment to once daily, supervised slow-release oral morphine. They then reported up to 8 weeks progress and return to methadone. Fifteen managed the transfer without difficulty, three returning to MMT prematurely. Reports of symptoms, side effects and preferences over up to six weeks in the 15 were positive, about three quarters preferring the morphine tablets, only one in five preferring the original methadone. While this is not scientific proof of a superior treatment, it is certainly an indication that morphine can be an acceptable alternative for most MMT patients, with certain reported benefits in a proportion of them.

The initial conversion ratio used was 3.5:1 but every single patient required increased doses for withdrawal symptoms, up to an average of 4.6:1 ... thus, for example, a patient on 100mg of methadone might need up to 460mg of morphine. At least two of the 11 cases (18%) returned to MMT on higher doses (45 to 50 and 120 to 130). One of these, interestingly, was already on the maximum dose according to the range quoted (25-120mg daily), but evidently needed still more on medical review when returning to methadone.

The mean methadone dose in this Adelaide trial at 78mg daily is higher than previous reports. However, it is likely that the optimal mean dose is yet to be reached, although increases are happening slowly elsewhere (D'Aunno et al). Until the mean dose of methadone is nearer 100mg (like Dole's very first report) it is probable in my view that a proportion of patients will suffer, simply by being prescribed inadequate doses. The lowest doses overall may be in England and Victoria (Aust) where one finds poor quality maintenance treatment along with either too much supervision (Victoria) or too little, as in the UK. New South Wales also has many treatment deficiencies, most glaring being a lack of treatment services in high risk areas such as the Hunter Valley, South-western and inner Sydney. There are also unreasonable restrictions and a lack of flexibility in some aspects of management, especially with buprenorphine.

I understand that in NSW, morphine has been approved for over 100 patients who have been previously registered as dependency cases. The approvals are mostly for slow release oral morphine for 'pain management', often after motor accidents, infections or skin grafts after overdoses. Supervision of doses is not always compulsory. It is not usually possible to completely separate an individual requirement for opiates for (1) dependency or (2) analgesia purposes . . . and it may not matter, except for some legal aspects.

This study from Adelaide adds further evidence that a wider variety of opioids can be safe and effective in dependency situations, and the old view of 'methadone for dependency and morphine for pain' is dated and arbitrary. Thus we now need to find out if we can improve on 'trial and error' to determine optimal management for our patients using methadone, buprenorphine or alternative oral or even parenteral opioids in pharmacotherapy for dependence.

Congratulations to *Addiction* for showcasing this seminal study as the lead article for the month. Note this study followed a rigorous report by the same authors on morphine's pharmacokinetics. The first such report I can find is from Dr. Sherman in Melbourne, followed by Whitton et al in Sydney (both 1996). [Contact *Methadone Today* for the list of references.]

**Editor's Note:** As this study demonstrates, many current pharmaceutical opioids may be useful in the treatment of opiate addiction. There is no good reason why more medication options should not be available--currently, the only legally available opioid medications in the U.S. are methadone and buprenorphine.\* For the small percentage of opiate addicts who do not respond well to methadone or buprenorphine, other medications should be available. Other opioid medications that may be suitable for the treatment of opiate addiction include long-acting oral morphine, codeine [which has already been used for this purpose formally or informally in countries such as Germany and Canada], and even hydrocodone in the form of a patch. The hydrocodone patch has been used in some chronic pain patients. The lack of such medication options may have more to do with politics and drug prohibition than with medicine and the best interests of patients.

\*LAAM is no longer available [for information see Sept. issue].

**ARM Chapter News (from p. 1).**

<http://www.johnsoninstitute.com>. ARM-DC has been working with the DC Department of Health Addiction Prevention and Recovery Administration to assist in the transition from publicly funded MMT (methadone maintenance treatment) to a voucher system, one of the two existing voucher systems for opiate addiction treatment in the USA (the other is in Albuquerque, NM).

**ARM-FL** – Welcomes **American Association for the Treatment of Opioid Dependency** Conference to Florida. Despite the weather and hurricane damage, ARM-FL members will attend AATOD in force. ARM-FL will sponsor a booth at this conference, together with the members of the CSAT Patients Support and Community Education campaign. Members are continuing to work with the Florida State Methadone Authority on the revision of the Florida methadone regulations. We hope that soon Florida patients will be able to have extended take homes, as allowed by the Federal Regulations.

**ARM-LA** – co-sponsors the 5<sup>th</sup> National Harm Reduction Conference “Working Under Fire: Drug Users Health and Justice 2004” in New Orleans Nov. 11-14. More information can be found about the 5<sup>th</sup> National Harm Reduction Conference at <http://www.harmreduction.org>. This Chapter will host an informational booth at the conference, which is attended by drug users, front line workers, researchers, case-managers, academics, politicians and scientists.

**ARM-MA** – was a sponsor of the Faces and Voices of Recovery training session “The Power of Story and Persuasion: fighting stigma and discrimination. This one-day training brought recovery advocates from all over the North East together to strategize on methods to fight stigma and discrimination. More information about the FAVOR trainings can be found at <http://www.facesandvoicesofrecovery.org>

**ARM-MD** – Baltimore County is suing an existing MMT provider, trying to force them to close, on the basis that opiate addicts in treatment are not disabled and thus are not protected by the **Americans with Disabilities Act**. This case has been dragging on for more than two years. ARM-MD members have testified as expert witnesses and appeared at County zoning hearings on the issue. If Baltimore County wins this case, it will set a very bad precedent for other OTPs facing NIMBY (Not In My Backyard) issues. Ellen Weber,

the author of TAP (Technical Assistance Publication) 14 (Siting Drug and Alcohol Treatment Programs: Legal Challenges to the NIMBY Syndrome), also has been assisting with this important court case. If you would like to help with this case, please contact ARM\*..

**ARM-ME** – Continues to work with the State Methadone Authority to ameliorate the effects of a spate of bad publicity, and some very anti-methadone residents, who have been trying hard to ban this treatment in Maine. In particular, the Chief of Police is very anti-methadone and continues to wage war against the treatment. However, the patients and providers are staying strong and continuing to educate Mainers about the FACTS of opiate addiction treatment, instead of the myths.

**ARM-MI (DONT)** Publishes the longest-running patient advocacy newsletter (**Methadone Today**) to date (9 issues per year). August '04 began their 10<sup>th</sup> consecutive year in print. Back issues of the newsletter can be found at their web site, <http://www.methadonetoday.org> For ordering subscriptions and personalized, laminated Medical Alert Cards, see pg. 4.

**ARM-NM** – This chapter has been involved in the process of convincing the State Bureau of Prisons that it is more cost effective to provide MAT to prisoners, than to treat them for the complications of cold turkey detox and their untreated addictions. Through the efforts of this ARM chapter and many others, the State of NM is the first to provide MAT in their local jails and prisons to current patients and also to untreated addicts. This should be the policy across the United States. If you want to help with this issue, contact ARM\*.

**ARM-Pittsburgh** – Chapter members have been working steadily with the public treatment provider to bring them to best practices treatment. Members also participated in a city-wide rally to restore drug treatment money that was in peril due to extensive budget cuts. Due to public outcry, the drug treatment money has been restored in Pittsburgh.

**ARM-MO-KAN** – Terri Martinez, Director, was nominated for the Johnson Institute “America Honors Recovery” award, which honors individuals who have overcome their circumstances, given back to their communities and continues to help those still suffering from addiction. Ms. Martinez also gave a presentation on MAT Advocacy at the Missouri State Conference on Substance Abuse. ARM-MO-KAN

sponsors”Addiction Treatment Watchdog” <http://www.atwatchdog.org>, the large patient centered opiate addiction website.

**ARM-SF** – Members have met with Mayor Gavin Newsome and the health department to voice their concerns about the San Francisco Office Based Opiate Addiction Treatment (OBOAT) system. There have been a lot of problems, but we hope that with the assistance of the very able ARM-SF members, this OBOT system can be up and running as smoothly as those in other cities. Kudos to ARM-SF for taking on this project.

**ARM-SoCal** – is trying to educate San Diego County about the importance of medication assisted treatment in drug court. Several patients have been told that they have to taper from their medication in order to participate in drug court, and if they continue with medication, they will be sent to jail. Unfortunately, we hear of cases like this all over the country. Thankfully, the providers in San Diego county have partnered with ARM to try to educate the court system, but so far there has been no change in policy--patients are still being forced to taper, regardless of what their medical doctors advise. This issue has to be addressed at the Federal level, and soon.

**ARM-TX** – Andrea Crosby has accepted a position on the TOTA Board of Directors. Texas Opioid Treatment Association is the only State organization that includes both patients and providers in the same organization, let alone the same room. We hope that the TOTA model will be copied by other state and local treatment associations. Remember, without the patients, there would be no “treatment”.

**ARM-Upstate** – Albany, NY is the site of the newest OBOT. This is a (**Cont. p. 4**)

**Last month, we announced that there would be another article on Medical Maintenance in this issue.**

**Due to the ARM Chapter information, we did not have enough room to include it. However, it will be in the November '04 issue--barring an emergency.**

**Thank you for your patience and understanding.**

**Beth & Aaron**

### Leadership Conference (from p. 1)

was to allow a meeting to declare itself open to DDF persons and encourage their sharing at a regular meeting, not a special meeting where most would not feel welcome unless they had the same problem. When DDF was first introduced in CT, three meetings voted to be DDF meetings. Within 30 days, two had changed their minds. One held out for about a year and changed its mind because the state board decided they would not be allowed on the meeting schedule, and they did not have enough income. I also discussed the prejudice against methadone maintenance patients.

Hopefully, all who were there could see that there were problems with some twelve step groups in regard to dual diagnosis and methadone maintenance. Some such groups do not accept or are not welcoming enough to dually diagnosed individuals or methadone maintenance patients.

The late afternoon session was split into three groups: Women, Co-occurring Disorders & Trauma, A Place to Call My Own--Recovering From Homelessness, and Back to Work--Helping persons with co-occurring disorders find a place in the working world.

**Editor's Note:** There has historically been suspicion among some twelve step groups toward medication-based addiction treatment in general, and particularly toward methadone maintenance treatment.

Narcotics Anonymous (NA) adopted a specific policy in regard to methadone maintenance treatment. It is obvious from reading this policy that NA takes a dim view of methadone treatment. Essentially the policy mandates that at meetings, methadone patients be treated just like an individual actively abusing illicit drugs. Such individuals may attend meetings but may not speak during them.

## Dual Diagnosis: A brief clinical discussion

A dually diagnosed patient suffers from both drug addiction and mental illness. When treating a dually diagnosed patient, it is important to try to understand the interplay between the addiction and the mental illness in the individual patient. For example, some patients originally suffered from some kind of mental illness and began 'self-medicating' it with alcohol or illicit drugs, thus becoming addicted. This has serious clinical significance, as the drug abuse may be masking mental illness.

In the context of opiate agonist treatment, medication dosage adequacy is of particular importance. Inadequate methadone dosage may aggravate or intensify the dually diagnosed patient's mental illness. There is also some evidence that methadone has some anti-depressant and anti-anxiety properties.

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DONT 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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**IT DOESN'T MATTER WHAT OTHERS DO--IT'S WHAT YOU DO THAT COUNTS. PLEASE, do your part--GIVE WHAT YOU CAN.**

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In the context of opiate agonist treatment, another important issue is that of medications used to treat certain mental illnesses. Some of these medications have the potential to interact with opiate agonist treatment medications (i.e., methadone).

Note that benzodiazepines (i.e., Valium) are sometimes used on a short-term or long-term basis in the treatment of anxiety disorders. Because of their abuse potential, benzodiazepines need to be used with caution in individuals with an addiction history.

Some methadone clinics have banned patients from using benzodiazepines altogether, especially when prescribed on a long-term basis. However, we disagree with such a blanket prohibition. There are a small number of methadone patients who benefit from short-term or long-term benzodiazepine prescriptions.

We would like to see more methadone clinics that train and educate their staff regarding dual diagnosis and relevant clinical issues, including the above. In regard to the actual treatment of mental illness, few methadone clinics appear equipped to do so 'in-house'--most do not have a psychologist or psychiatrist on-site with the training to treat serious mental illness.

### ARM Chapter News (from p. 3).

hospital affiliated OBOT. A member of ARM was interviewed for a local news show that did a very favorable segment on this new OBOT. Long-term, stable patients have been integrated into a medical model practice where they see a doctor once a month for their medications at a cost of ¼ of the current OTP cost. If Albany can do it, so can YOUR city. For more information or a copy of the taped news segment, contact ARM.\*

**ARM-VT** – Members at the only OTP in Vermont have been busy setting up a Patient Advisory Council and working with the local Opiate Dependence Resource Center (<http://www.methadone.net>) to improve treatment quality. They are also working with the local Department of Health to start van based dosing, the first such project in a very rural area.

**ARM-VA** – working with the Virginia Alliance of Methadone Advocates (VAMA) on very serious NIMBY issues, especially in Roanoke, and also another court case where a patient has been put in jail for three years because she continued her medical treatment despite a judge's order to taper. The ACLU and other national MAT advocates have testified in this lady's case, but right now, she sits in jail. We do have some friends in the press in Virginia, but we also have a lot of enemies. Without a federal response on this issue, patients will continue to be incarcerated because they need medication to treat their disease. If you want to help with this issue, contact ARM [[\\*DCReardon@aol.com](mailto:DCReardon@aol.com)].

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