

Methadone Today

The official newsletter of DONT-BY PATIENTS, FOR PATIENTS

October 2006

Volume XI Number VI

In Memoriam--

Dr. Vincent Dole, 'Father of MMT'

We are sad to report that Dr. Vincent P. Dole passed away in August. Dr. Dole and his wife, Dr. Marie Nyswander who predeceased him, bravely and compassionately researched medication-based treatment for opiate addiction at a time when few researchers were interested in working with opiate addicts. Drs. Dole and Nyswander dared to think 'out of the box', when most experts had long ago given up on the idea of maintenance treatment.

They believed that maintenance therapy deserved a rethink but like their predecessors found that short-acting opiates were not suitable. When their subjects were being maintained on short-acting opiates like morphine, they did not function normally. Much of the time, they were either in withdrawal, intoxicated, or simply waiting for the next injection. However, Drs. Dole and Nyswander had a synthetic opioid medication available to them that did not exist in the 19th Century, when maintenance had last been attempted. Methadone (A.K.A. dolophine) had been developed in World War II by Nazi Germany, originally for purposes of pain management, but Germany never got a chance to use it, and after their defeat, the allies got methadone and other medications they had developed, among other 'spoils' of war.

Methadone is longer acting than morphine and the other short-acting opiates that Drs. Dole and Nyswander had tried previously and had been used to maintain addicts in the 19th Century. When Drs. Dole and Nyswander transferred the subjects to methadone and stabilized them on a sufficient dose, they started to function normally. These individuals, seemingly intractable opiate addicts, became interested in outside activities--one subject, asked if he could paint—a hobby he used to be involved in years before and another asked for permission to take classes.

Dr. Dole was being heavily pressured by a federal government agency that eventually became the DEA to abandon his research, but he and Dr. Nyswander bravely defied them. Dr. Dole modestly insisted that it was Dr. Nyswander who was the courageous one. Unlike Dr. Nyswander, he had tenure (**Ct. p. 2**)

Dear Methadone Today,

I have been a methadone patient for three years, and it has completely changed my life. However, I have recently been charged with DUI (driving under the influence of alcohol). My blood alcohol level was .082, and in Pennsylvania, I would only go on probation for six months. I would not have to do any jail time, nor would I lose my license.

However, when the police asked me if I was on medication, I was stupidly honest and told him about the methadone. Because of that, I am being charged with driving under the influence of a controlled substance, and I am facing from 72 hours [minimum] up to 6 MONTHS in jail. My addiction took me to places that I am ashamed of, and my criminal record score is high. Therefore, I am probably facing closer to the six months.

My recovery and methadone treatment has changed my life. I am now married to a wonderful guy who has never used in his life. I own a home and have my own housecleaning business. I clean homes for very wealthy people who trust me with keys to their enormous homes. If I get locked up for more than week, I can basically kiss my customers and my business goodbye. My customers are used to being catered to, and they will not wait for me while I do a jail sentence.

I am terrified and sincerely need some advice. **-R.B.**

Dear R.B.,

We are sorry that you are in this predicament. We recommend that you find an attorney that has an open mind about methadone treatment and is willing to research the issues.

Different states have different laws regarding driving while under the influence of alcohol and driving under the influence of prescription or illicit drugs. States may vary in how they handle driving while under the influence of legitimately prescribed drugs--and of course, the maximum and minimum sentences also vary among states.

The facts about methadone treatment and driving are as follows: (**Cont. p. 3**)

wait for the 4 pm group. I had borrowed my boyfriend's car and had no way to let him know what was going on, so consequently when I returned home, I caught hell.

My question to you is what recourse do I have if any? I'm very upset about this and don't want to just let it go. Any advice would be greatly appreciated. **-Ginger**

Dear Ginger,

Thank you for writing in, and we are glad that you find the newsletter and website informative.

It is a shame that you and other patients are being hassled by these kinds of mistakes. We hope that this was an unintentional error rather than a staff member deliberately giving you a difficult time.

However, we fail to understand why the head counselor or some other counselor who was at the clinic at the time could not have gotten out your file, sat down with you, and determined whether you really did miss a group session. If you had not missed any sessions, that counselor could have signed you off-- (**Ct p. 3**)



Dear Methadone Today,

I've found your newsletter very informative. I have also looked through your website before, and I think it's well put together.

I've been treated at the same methadone clinic for over a year now with positive results (I went from 115 to 70 mg/d). I'm on a block grant and am required to attend two groups and two individual sessions per month, which I take seriously and have never missed. When I went in to dose on Monday (I get take homes and only come in M-W-F), I was informed that I had one more group to do. I went and got my counselor, and we went through my chart, as I knew I hadn't missed a session ever. My counselor wrote down all the dates that I attended groups for the last 4 months and gave it to the cashier who I thought would correct it. When I came in on Wednesday, the same cashier said I was tagged and couldn't dose until I did a group; when I went to see my counselor, the cashier seemed to take pleasure in telling me that she left for a 2 week vacation, so I had no choice but to

Dr. Vincent Dole (from p. 1).

at Rockefeller Institute for Medical Research, which provided him some protection from losing his job, etc. In the end, the findings of their methadone maintenance research could not be denied—policymakers saw methadone treatment as a way of dealing with an increasing number of heroin addicts. The alternative to incarcerating heroin addicts was resulting in a 95% or higher relapse rate. Once- a-day oral dosing made methadone treatment feasible and affordable.

Dr. Vincent Dole continued to speak about opiate addiction treatment into old age—even providing *Methadone Today* with an interview several years back. Dr. Dole had been critical of the clinic system and lamented the negative attitudes about methadone patients held by some methadone clinic staff.

Dr. Dole was always caring and compassionate—especially to people suffering from drug addiction. His contribution to humanity should not be forgotten.

Dear Advocate (from p. 4).

anything but a genuine concern for children is that it prohibits methadone clinics from being *five miles* from schools, etc. (assuming you are correct that the regulation does not allow methadone clinics within *5 miles* of schools or daycare facilities). Clearly the politicians involved in passing this regulation were interested in making the distance from schools, etc., that methadone clinics would not be allowed to operate within as large as possible as a way of proving to voters that they really care about protecting children and to make sure that no other politician could 'one-up' them by proposing an even greater distance. We would venture to guess that few children in the U.S. are walking five miles to school except possibly in a **very** remote, sparsely populated area.

The hypocrisy of this is hard to miss. In the majority of medium size to large cities, one couldn't go any five-mile stretch without finding a couple of liquor stores. Maybe policymakers and the public should question why in many cities there are greater restrictions on where a methadone clinic can operate than on where a liquor store can operate—although there are certainly some local lawmakers who are concerned about liquor stores and the potential negative impact that an overabundance of them can have on a community.

Even if one believes the negative stereotypes associated with methadone clinics, liquor stores still have a greater potential for problems. If nothing else, people should consider the difference between a methadone clinic and a liquor store in operating hours. Absent very rare exceptions, even methadone clinics with expanded operating hours only stay open until 6 - 7 pm, and the closing time is typically even earlier on Saturdays, whereas liquor stores stay open until fairly late at night, depending on state and local government regulations on when they must close. All the concerns that people have about methadone clinics are known to be a problem at at least some liquor stores--loitering, drug dealing, etc. Also, it is no small distinction that many people who go to a liquor store are going in order to become intoxicated, even though they are not actually going to get drunk AT the liquor store, while people going to a methadone clinic are patients attending a methadone clinic for the specific purpose of ceasing drug abuse, and most of them are indeed making a serious attempt at recovering from drug addiction.

Perhaps the strongest proof that methadone clinics are not the hot spots for crime and trouble that the public has been led to believe is the number of clinics that operate right under the nose of nearby residents. Some methadone clinics operate out of a medical plaza—alongside doctor and dentist offices. There is a common parking lot, and each office/clinic has a separate door (like a shopping center). Typically, no one driving by these medical plazas would be able to tell that one of the suites is occupied by a methadone clinic. There are no people waiting in line outside, and loitering outside is not permitted.

The point is that regulations regarding where a methadone clinic can locate should not be more harsh than regulations regarding

where various business can locate that are associated with far more problems than methadone clinics. Anyway, most of the supposed problems associated with methadone clinics never actually materialized. In most of the cases where a methadone clinic opened in spite of community opposition, neighbors admitted that their worst fears were not realized. We also should not forget that methadone clinics are providers of a medical treatment—to regulate methadone clinics in the same manner that liquor stores and bars are regulated plays into the myth that methadone treatment is simply substituting one addiction for another, rather than treating methadone treatment as the effective medical treatment that it is.

Furthermore, you are absolutely right that making methadone clinics more accessible will actually reduce crime in the area. In past issues, we have reported on the mountain of research indicating that methadone treatment greatly reduces criminal activity by opiate addicts. The public, as well as lawmakers, need to be educated about this. Methadone clinics should be looked at as a crime prevention tool.

One more point we should make is that treatment providers do have a role to play in combating NIMBY sentiment. First, by writing the local media regarding the facts about methadone treatment and why it is important that methadone treatment be accessible. Second, by cultivating a relationship with community groups so that treatment providers can address and resolve community grievances before it becomes a major issue. Third, by managing their methadone clinics in a way that minimizes the very problems that neighbors are worried about. That means having security guards that will patrol outside the clinic to prevent loitering and drug dealing if necessary. Finally, by choosing the best location possible when opening a new methadone clinic. Ironically, the ordinances and regulations that have restricted where methadone clinics can operate tend to cause more problems than they prevent, since they effectively limit the choices treatment providers have as far as potential locations for opening a new methadone clinic.

****The Doctor Column will return next issue.***

To Our Subscribers:

Please accept our apologies for missing the last issue of *Methadone Today*. Old software and equipment that we can't afford to replace are causing conflicts and delaying publication.

Your subscription will be extended to give you 9 issues. I will make the adjustment in my database. If you feel you are owed an issue after my adjustment, please let me know right away. Your renewal date is always on your address label.

We appreciate your support, and your satisfaction is always important to us!

Thank you,
Beth Francisco, Senior Editor

Dear R.B. (from p. 1).

1. A methadone maintenance patient stabilized on the proper dose of methadone is as capable of driving as a 'normal' person. A stable methadone patient does not experience intoxication from his/her methadone dose. If that is not enough, there have been research studies that specifically compared driving performance of methadone patients to a control group of 'normal' drivers, which concluded that methadone patients are not impaired and can operate a vehicle as well as any other driver.

2. Alcohol interacts with methadone. When you initially ingest alcohol, it increases the effect of the methadone, resulting in intoxication. However, chronic use speeds up the metabolism of methadone, the result being that you would feel as if your methadone dose wore off early. In other words, a methadone patient with a blood alcohol level of .082 may be more impaired than someone with the same blood alcohol level who isn't on any prescribed medications.

So, even though your methadone dose would normally not impair your ability to drive, it could be argued that you were impaired by your methadone dose because of the interaction between methadone and the alcohol you had ingested. That does not mean that we think that this is fair--at least when it comes to the difference in the probable sentence between a simple DUI and driving under the influence of a controlled substance. This means that someone who is not on methadone but has a significantly higher blood alcohol level could receive a much more lenient sentence than you, even though s/he [depending on the blood alcohol level] may have been more impaired/intoxicated than you were.

The lesson for methadone patients is to avoid drinking alcohol, especially if you are going to be driving. The interaction between alcohol and methadone may increase the degree of impairment, increasing the likelihood of a serious or fatal accident and possibly set you up for greater criminal penalties than a typical DUI.

Obviously, driving under the influence of alcohol or illicit drugs is dangerous and a bad idea regardless. I am sure you regret what has turned out to be a costly mistake—driving under the influence of alcohol. Furthermore, serving even a relatively short amount of jail or prison time is a problem for methadone patients because the likelihood of getting the jail or prison to medicate you is low, so you may be suffering from opioid withdrawal while in jail or prison. Better to just avoid driving under the influence rather than worrying

about what sentence you'll receive if you get caught.

We sincerely hope that your attorney can at least get a work release arrangement that will allow you to keep your business and allow you to dose.

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

allowing you to dose without attending the group session.

Second of all, we feel that part of the problem is that at many methadone clinics, patients are never trusted or given the benefit of the doubt. You have a good record and have been stable and abstinent of illicit drugs long enough to have earned take-homes. If your counselor is not there when such a problem arises, staff could actually trust you enough to let you dose.** Most patients who have earned take homes will not be willing to lose these privileges just to get out of one group session. We can understand why in many situations that it is a good idea for clinic staff to verify something rather than take the patient's word for it. Even assuming that every patient is always truthful with the staff, people can be mistaken (i.e., a patient thinks that they attended four sessions that month, but one of the sessions s/he remembers attending was actually at the end of the previous month--so in reality, they may have only attended three sessions that month). The problem is that in some cases, clinic staff are not even bothering to verify or double check what the patient is

saying before dismissing the patient out-of-hand.

Some such cases where the patient is not believed just do not make any sense. In one case, a doctor insisted that the patient was way over due for a TB test because the last one was recorded in the file was over a year ago.* The patient told the doctor that a TB test was done only three months prior, but the doctor did not believe him.

What happened was that when the TB test was administered 2-3 months ago, it had been entered in their computer but was never written in the file. The consequences of this was not serious--an extra TB test was administered--but it is disturbing that a doctor would believe that a long-time stable patient was lying rather than entertain the possibility that an overworked staff member had neglected to note the test in the patient's file. The assumption that if there is a discrepancy, the patient must be lying was there, even in a case where there would be no good reason for a patient to lie--the TB test was not going to cost the patient extra money.

Unfortunately, we do not know that there is any real recourse available. Perhaps you should formally complain, so that the next time an issue like this arises, it will hopefully be handled differently--though preferably such a problem never comes up to begin with. If you want to make a formal complaint, ask your counselor for the name and contact information for the patients' rights advisor. S/he should give you this information, as well as specifics about the grievance procedure. In fact, we believe that your clinic has this information posted somewhere in the main lobby. On the other hand, you may just want to complain to your clinic directly--this may make more sense, and be more likely to result in a change in the way they handle such issues in the future. Complain to your counselor about it and ask if the clinic has their own internal system for handling complaints or grievances. At the least, your clinic may have a suggestion box where you can put your ideas, complaints, or advice. Using a suggestion box is a more attractive option to some patients because they can have a general complaint heard anonymously, as you don't have to put your name on it.

*In fact, a few years later, the same thing happened to this patient. The TB test was not noted in the file. However, this time, the doctor checked with the nurse who was able to verify that she administered the TB test without even looking it up on the computer because it was done less than two months prior. . . but at first, the doctor still did not seem to believe him. **(Cont. p. 4)**

Dear Methadone Today,

I want to address an issue that is not something my individual clinic can change, but it is a regulation that I feel needs changing!

The family that owns the clinic I attend has recently been trying to open a new clinic in my area. I live about 50 miles from the actual clinic that I attend; and there is a HUGE need for a clinic in the city where I live! They have been trying for about a year now to find a location for the new clinic; the only problem is the NIMBY (Not In My Back Yard) attitude. . . and the regulation that states a clinic CANNOT be opened within a five mile radius of a school or daycare. This makes finding a location for a clinic IMPOSSIBLE! This rule not only applies to public/private schools and large commercial daycare centers but also to small in-home daycare centers, churches, playschools, etc. IT IS IMPOSSIBLE to find a place that meets the regulations! Plus, even IF it was possible to find a place, it would make it more difficult for patients to get to the clinic! The idea should be to make it as easy as possible for patients to seek treatment.

Many addicts do not own cars and must rely on public transportation. . . so WHY would you open a clinic SO FAR out of town that public transit doesn't go there? Plus, don't overlook the obvious discriminatory attitude of this law! We allow for JAILS, COURTHOUSES, LIQUOR STORES, BARS, ADULT STORES, etc., to be located near schools/daycare, so WHY NOT a methadone clinic? What makes a methadone clinic more dangerous than a "regular" doctor's office?

On a final note, my JOB is teaching children! I am a MMT patient, and I am still a VERY GOOD teacher! Why should I be allowed to teach children but not be allowed to have my clinic located within five miles of them? There are MANY MMT patients who are wonderful parents, teachers, etc., so the idea that just because we are in MMT makes us dangerous to be within five miles of a school/daycare is RIDICULOUS!

My personal feeling is that no one wants a clinic nearby because that would force everyone to recognize that there is a drug problem in their town. But people need to wake up. Chances are that by the time their children are in high school, they are already going to school with, or are friends with, someone who is using drugs or who has parents who are using illicit drugs. It is only a matter of time before their teens are offered drugs! It would only make their children more SAFE to offer treatment to those addicts so that there will be fewer addicts on the streets waiting to sell drugs to their children. Not to mention the fact that if we offer more treatment centers it will lower the crime rate that is associated with drug addiction. People fear that a clinic will ATTRACT addicts and

crime to their area; the truth is that addiction and crime is ALREADY present! By offering treatment centers, it will only help the current situation. Not to mention the tax dollars it will save. A lot of money is spent catching drug dealers/users, prosecuting them, and housing them in jails. Enabling a clinic to open in my area will HELP our town, NOT hurt it!

I want to get the word out to all MMT patients to help advocate to get this regulation for a clinic not to be allowed within five miles of schools/daycares overturned! I have already started writing letters to the newspapers and lawmakers, and I encourage all of you to do the same. **-An Advocate**

Dear Advocate,

In past issues, we have written extensively about the NIMBY phenomenon. Sometimes the NIMBY reaction to the proposed opening of a methadone clinic rivals the reaction of communities to locating an incinerator or landfill nearby. Some politicians share part of the blame for pandering to anti-methadone clinic hysteria by passing laws limiting where methadone clinics can locate and requiring providers to jump through regulatory hoops before they can open a new clinic. A regulation or ordinance that a methadone clinic cannot operate within five miles of schools or daycare facilities smacks of political pandering so that they can proudly say that they have a record of "protecting children". One of the reasons we believe that the sponsors of such a regulation are likely motivated by **(Cont. p. 2)**

Dear Ginger (From. p. 3).

**There are cases for which regulatory, liability, and/or medical reasons specific paperwork/verification is required before dosing a patient—clinic staff cannot merely rely on trust. A perfect example of this is if a patient does not return to his/her clinic until a week after his/her scheduled day (i.e., s/he has not been medicated by the clinic for a week). In this case, the clinic could not provide more than a 30 mg dose of methadone to the patient unless the patient has written documentation that s/he has been medicated in the last seven days by another methadone clinic (guest dosing) or during a hospital stay. In addition to regulatory requirements, such documentation is necessary to protect the patient. If the patient has not taken any methadone for a week, his/her tolerance level may have decreased to the point that taking his/her normal daily dose might result in an overdose. With the potential for dire consequences, clinic staff cannot just take the patient at his/her word.

Beth Francisco, Senior Editor
Aaron Rolnick, Managing Editor
Methadone Today (Vol. XI, No. VI) Oct. 2006
P.O. Box 90337
Burton, MI 48509-0337
<http://www.methadonetoday.org>
E-mail: bethfrancisco@sbcglobal.net

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.

Won't you please help us cover costs of the newsletter, web site, etc. Your donations are tax deductible.
IT DOESN'T MATTER WHAT OTHERS DO—IT'S WHAT YOU DO THAT COUNTS. PLEASE, do your part--GIVE WHAT YOU CAN.

**This newsletter is made possible by
subscriptions and donations only**

- Single-copy *patient/individual* subscription to **Methadone Today** \$20 yr
- DONT membership only - \$10/yr.
- Subscription to **Methadone Today with membership** - \$27 (save \$3)
- Single-copy *clinic/institution* - \$35 yr /9 issues - you may reprint up to 100/mo.
 - \$50 yr. - to 250 copies/mo. \$100 - to 500 copies/mo.
- Clinic subscription (\$350/yr. - 100 copies/mo. will be delivered to clinic).
- Back issues - \$10 each - Vol. I - X (or \$35 all issues--Vol I-XI to date)
- Donation of \$ _____ to send **Methadone Today** to someone who cannot afford it or to educate policy makers, clinic staff and/or the general public.
- Enclosed are _____ 39-cent (or other) stamps to help with postage.
- Donation of \$ _____ to the **Methadone Today** web site.
- Personalized, laminated methadone MEDIC ALERT card (send your name, clinic's name, clinic's phone number, & self-addressed, stamped envelope [SASE] - cannot be processed without preceding) - \$5 with subscription or membership, \$8 without.

Name _____ Phone: _____

Address _____

City/State/Zip _____

E-mail: _____

For Medical Alert Card only:

Clinic Name _____ Clinic Phone: _____