PROVINCIAL METHADONE MAINTENANCE PROGRAM

"An Overview with Particular Focus on Client Perspective"

by John Cameron and Wayne Moore
on behalf of the DTES HIV/IDU Consumers' Board

OVERVIEW

Methadone serves as a medically approved substitute for heroin to address the harms of opioid addiction.*

HISTORY

Methadone was initially synthesized in Germany during World War II as an analgesic alternative to morphine. It was first used as a maintenance treatment for drug addiction in 1964 in the United States. The AIDS epidemic and, to some degree, the hepatitis epidemic, provided the impetus for widespread use of methadone as a valid component of the harm reduction continuum during the early 1980's and continuing today.

CURRENT STATUS (NUMBERS)

There are presently 15,000 persons in Canada on Methadone Maintenance Therapy (MMT). As of October 2000, there were 6,000 persons on MMT in BC (and growing). These numbers clearly suggest that MMT is used as the primary treatment for opiate addiction, at the exclusion of other treatment options and alternatives.

BENEFITS

Numerous studies (VIDUS, for one) have shown conclusively that MMT is associated with a reduction in daily heroin use, drug overdose, street and property crime, participation in sex trade, death rates, AIDS and hepatitis transmission and improved pregnancy outcomes.

In economic terms, an investment of $6 million results in a $30 million savings in social costs.

Considerable information exists on the benefits accrued from those clients where MMT acts as a successful intervention; very little, if any, data exists for clients where MMT was a failure. More studies focusing on clinical outcomes are needed.

THE NATURE OF METHADONE

Oral

- the key to reducing AIDS and hepatitis transmission in IDUs

Long-acting

- effects last 24 to 36 hours (daily dosage); heroin, the average addict requires 4 fixes per day; LAAD, effects last 48 hours or longer.

Social Functioning

- not "high" or "dope sick"

Tolerance develops slowly.

Medically safe.

- does not appear to have major long-term or short-term side effects
- chemically "pure" as compared to street drugs

Low delivery costs.

Addictiveness

- withdrawal from heroin or morphine takes 4 days on average; methadone withdrawal takes over a month - we may be sentencing addicts to a lifetime of addiction to methadone (note: the growing numbers of persons in detox for methadone withdrawal).

Blockade effect.

- Methadone use reduces the effects from the addict's usual doses of street opioids. While this may act as a deterrent for those in the program to use opioids, it is often disastrous for those who abandon MMT. They may substitute cocaine for heroin in order to get "high" or use higher doses of heroin or use both cocaine and heroin.

METHADONE, HEPATITIS AND AIDS

Undoubtedly the most beneficial benefit of MMT is in reducing the transmission of AIDS and hepatitis. MMT is perhaps the most cost effective way of preventing the spread of HIV and HCV in IDUs.

MMT must also provide consideration for those who are already infected (note that over 70% of IDUs in Greater Vancouver are Hepatitis C positive and over 34% are HIV positive).

For those already infected, methadone delivery must go hand in hand with HIV/Hep C treatment. Methadone prescribers are seldom specialists in HIV and hepatitis. Therefore, collaboration between the patient's doctors is required.

For Hepatitis C positive clients, liver function must be constantly monitored because of the impact of methadone on the liver.

It must be recognized that those on MMT may be reluctant to, or forget to, disclose their methadone treatment to GPs and other health service providers or when going in to surgery.

It must also be noted that methadone doctors have the right to override decisions made by the patient's other doctors.

Little is known about the interactions between methadone and prescribed drugs; many dosage effects, however, are understood. Methadone changes the dosage requirements for almost all HIV medications including DDI, D4T, AZT, abacavir, nevirapine, ritonavir, viracept and efavirenz.

A recent study in New York demonstrated that the infectivity of HIV is enhanced in vitro in the presence of methadone. This raises concerns about the use of methadone to treat opiate dependency in HIV-infected patients.

In general terms the health benefits derived from the stability that MMT provides must be weighed against the medical side effects of methadone. It should be noted that HIV positive clients on methadone are twice as likely to go on AIDS drug treatment.

METHADONE/PRESCRIBED DRUGS/STREET DRUGS

Once again, the drug interactions are poorly understood but dosage effects are documented. Methadone affects the dosage requirements of many drugs including valium, talwin and barbiturates, and vice versa. With alcohol, the effective dosage of methadone increases; with cocaine, it decreases.

METHADONE – BONES AND TEETH

At street level we persistently hear about and discuss bone and teeth problems that those on MMT insist results from long-term methadone usage. To date, no medical proof exists to prove, or disprove, a relationship between methadone use and bone/teeth problems. Practitioners insist it is a myth; clients maintain it is a reality.

METHADONE PROGRAM ADMIINISTRATION

The College of Physicians and Surgeons of BC administrates the Provincial Methadone Program. The Advisory Committee on Opioid Dependence, a standing committee of the CPS, oversees the Methadone Program and monitors prescription of methadone to ensure compliance with appropriate standards and treatment guidelines.

As politically incorrect and insensitive as it may sound, methadone doctors and dispensers act as legal "pushers"; they provide an addictive substance that the client needs. Clients seldom complain or reveal concerns and problems they experience with their methadone program (such as adherence) to their doctors or dispensers because of fears they may be penalized (worst of all their methadone removed). Even if addicts do

complain, these are no avenues to address their complaints other than the College of Physicians and Surgeons, an avenue that is inaccessible for the average street addict. Because there are never any complaints, it appears that MMT works flawlessly.

This is not to suggest that doctors and dispensers are part of some vast conspiracy to misuse clients while making money from them – but abuses are occurring and largely remain unrecognized and unaddressed. An accessible venue must be established where clients can raise issues and concerns with impunity.

METHADONE ACCESS

Methadone is provided through 3 venues: private practice physicians, community health centers and private methadone clinics.

Accessibility remains a major problem in rural areas. Access to methadone should be expanded in correctional institutions and hospitals. Obviously methadone dispensing should be carried out in conjunction with needle exchange.

Because most patients are Hep C positive and many HIV positive, methadone should be tied to AIDS/Hepatitis service and support systems.

METHADONE PROGRAM ASSESSMENT

Assessment for entry into MMT should consider many factors including age, medical history, other illnesses, addiction history, possible mental problems, ability to comply with the program, potential for recovery, etc.

Methadone maintenance should be reserved as treatment of last resort. At present in BC MMT is used as the preferred treatment for opiate addiction due to the absence of other alternatives and other treatment resources, for example, treatment centers. MMT is being applied as a blanket, economically efficient "cure all" for addiction.

In particular methadone should not be the first line therapy for opioid dependent youth, recognizing the probability that they may be sentenced to a lifetime methadone addiction. At present no guidelines exist for this population.

METHADONE SERVICE FEES

For the service of writing a methadone prescription, plus or minus counseling, the patient fee is $50 to $85 per month. An initial $50 assessment fee is also charged.

The doctor is also paid for regular "piss" tests. Two visits per week per patient may also be billed at $10 per visit.

In 1999, the total cost for MMT provincially was $2,725,011 for 4500 patients ($700 per patient annually).

Lucrative profits appear to propel the search for new clients and has helped methadone become the preferred treatment for addiction rather than other alternatives. We are seeing the systemic decline in the effectiveness of methadone maintenance due to growing departure from the direction of lower doses and time-limited treatment (ongoing maintenance rather than abstinence).

Each patient serves as a permanent "cash cow" for the doctor and dispenser. Is there an incentive for recovery when you may lose a permanent paying compliant customer?

METHADONE DELIVERY AND THE CLIENT

Tremendous controversy exists about the severe restrictions applied to patients taking methadone – restrictions which do not apply in any fashion to the prescribing of other equally or more dangerous narcotics. MMT must be provided in such a fashion that it does not interfere with the reality of clients' lives – work, schooling, child care, etc. The whole concept of MMT is to stabilize clients' lives so they can lead a normal productive existence.

It should be noted that working clients bear some of the costs of MMT and the present methadone delivery system may be a deterrent for return to work.

Numerous studies have shown that the longer that clients remained on MMT, the better the outcome. Productive behavior as measured by employment, school attendance, or homemaker status increased with length of treatment.

This must be balanced with the merits of dosage reduction and removal from MMT. Such process should involve client input and decision-making power.

One study demonstrated that standard MMT enhanced with weekly coping skills training, group attendance, and as-needed referrals to other services was a far more effective venue.

MONITORING – "PISS" TESTS

According to the College of Physicians and Surgeons perspective, urinalysis measures "performance" and "compliance" but not from the patient's viewpoint. Urinalysis is the most resented part of the program and is often punitive and seldom consistent. It has been clearly shown that "piss" tests are not an effective means of deterring drug use.

"Piss" tests should be used to provide a general picture of progress – not as a punitive measure to attain strict compliance without recognizing that "slips" are part of the process of recovery.

ALTERNATIVES

There is further need to explore the use of alternatives such as LAAM, Buprenorphine, laudanum and heroin maintenance.

SUMMARY

Methadone is an integral part of a spectrum of addiction services. It should be provided and administered as a treatment option within an entire array of harm reduction initiatives including rehabilitation, medical treatment, safe fixing sites, needle exchanges, treatment centers, prevention, etc. Methadone must be provided within a wide range of services, supports, and choices – not as a stand alone "cure all".

* Footnote: Methadone acts as a substitute for heroin, morphine, codeine and opioids in general, but not for cocaine.