Methadone for Substance Abuse

By:

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When taken orally once a day, methadone suppresses narcotic withdrawal for between 24 and 36 hours. Because methadone is effective in eliminating withdrawal symptoms, it is used in detoxifying opiate addicts. Methadone reduces the cravings associated with heroin use and blocks the high from heroin, but it does not provide the euphoric rush. Consequently, methadone patients do not experience the extreme highs and lows that result from the waxing and waning of heroin in blood levels. Ultimately, the patient remains physically dependent on the opioid, but is freed from the uncontrolled, compulsive, and disruptive behavior seen in heroin addicts. Furthermore, withdrawal from methadone is much slower than that from heroin.

The use of Methadone in the treatment of substance abuse is highly regulated by the state of Michigan. The strict natures of these laws tend to be unethical at times. The laws are very detailed as to who should receive methadone and the requirements that must be met in order to receive methadone. Methadone administrative rules not only violate the pharmacists’ code of ethics but ideology, deontology, and beneficence as well. Furthermore, there is still a stigmatism surrounding substance abuse.

Methadone is a scheduled 2 controlled substance in the state of Michigan. It has two indications for its use: (1) substance abuse, and (2) pain. Anyone with a license to prescribe controlled substances can subscribe methadone for pain. However, a separate license is required to prescribe methadone for treatment of withdrawal associated with addiction and must occur in a licensed treatment program. In addition, the laws are very detailed as to who should receive methadone and the requirements that must be met in order to receive methadone.

There are strict guidelines as to the necessary information that must be obtained by an authorized physician regarding the patient before the first dose can even be given. A physician within the program must document evidence of physiologic dependence, length of history of addiction, or any exceptions to criteria for admission. The physician must also ensure that a thorough medical history and physical examination be performed prior to administration of the first dose. However, in emergency situations, the initial dose of methadone may be given before the physical examination is performed. For detoxification, patients are administered methadone daily for not more than twenty-one days. Methadone administration is supposed to take place under close observation and
in reducing doses. An initial urine test is required and there is to be no take home medication during this time.

To be eligible for a methadone maintenance program, there are strict criteria for a patient to be admitted into a program. The patient must have undergone detoxification. The patient must be currently physiologically dependent upon narcotics and have at least a one year history of physiological dependence. The physician must look for signs and symptoms of narcotic dependence and a thorough physical examination, medical history, and personal history must be obtained. A patient who has been treated and then detoxified from a methadone maintenance program can be readmitted without evidence to support current physiological dependence. However, the patient has to have undergone at least six months of treatment and the physician must deem it to be medically necessary.

The patient is required to be evaluated by the physician at least once every sixty days and must participate in mandatory urinalysis at least once a week. The urinalysis is used to determine if the patient is taking their methadone and/or has relapsed. Urinalysis screens for opiates, methadone, barbiturates, amphetamines, cocaine, and any other drugs necessary. If the patient remains drug free for six months, and as long as the patient remains drug-free, urinalysis frequency can be changed to once a month.

The law also sets a time frame for when therapy should be discontinued. Voluntary withdrawal and discontinuation of methadone use is encouraged at an appropriate time when the patient is drug-free and able to ensure that they stay drug-free. Methadone maintenance treatment should be discontinued within two years of treatment initiation. However, the two year limit is not definitive. A patient can remain in the program if the physician feels that it is justifiable and requires re-evaluation on a yearly basis.

A patient can be eligible for take-home methadone following at least three months of treatment if they meet eligibility. In order to be eligible, the physician must believe that the patient is responsible enough to handle methadone at home. This means that the patient should demonstrate progress in rehabilitation, is responsible in handling the methadone, and is working, enrolled in an educational/training program, or has home responsibilities. Furthermore, the patient’s rehabilitation must be enhanced by decreasing the frequency of visits. If a patient meets all of the above criteria, the patient will be allowed a take home supply of no more than two days. If after two years, the patient is still in the program and meets the criteria, the patient is allowed a take home supply of no more than three days.

There are other exceptions in which patients may receive take-home methadone. First, if a patient has a disability that does not allow the patient to conform to the strict schedule of the treatment. Second, if a because of illness or a family or personal crisis the patient is unable to conform to the schedule, a
patient may be permitted a temporary reduced schedule. The patients must again demonstrate that he/she is responsible enough to handle methadone. At any one time, a patient may receive not more than a one week supply unless prior approval is obtained by the state methadone authority and the food and drug administration.

The law does grant some exceptions for which holiday supplies may be given with the approval of the state methadone authority. A one day supply may be given for the Fourth of July, Thanksgiving day, Christmas day, and New Year’s day. An additional one day supply may be provided for holidays which fall on a Monday. A one day supply may also be provided for official state holidays. These holidays include: Both Lincoln’s and Washington’s birthdays, Memorial Day, and Labor Day. However, not more than a three day supply of methadone shall be dispensed to any client because of holidays without prior approval.

However, there are no exceptions to the rules for patients who are admitted to the hospital while receiving treatment for narcotic addiction. When a patient is admitted to the hospital and informs the staff that they are currently undergoing methadone treatment, the hospital cannot simply start administering methadone to the patient. A staff pharmacist is required to verify patient enrollment in a methadone treatment clinic before the first dose can be administered. There are no exceptions to this rule for holidays or instances where the clinic is closed. Furthermore, patients who have take-home methadone privileges are not allowed to bring their methadone with them to take while in the hospital.

It is understandable that methadone is highly regulated given that it has the potential to be abused. In addition to its abuse potential it is being dispensed to patients with a history of addiction and there is a potential for patients to become addicted to methadone as well. However, there are times when these rules are too strict and prevent the patient from receiving the needed care that they deserve. Furthermore, there are times when the laws are too broad and could possibly lead to methadone addiction.

The methadone laws violate the Pharmacist’s Code of ethics and may violate a pharmacist’s personal code of ethics. The 1994 American Pharmacists Association Code of Ethics states that “A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner.” In certain instances the law prevents us from obeying the code of ethics. When the patient is admitted to the hospital and is currently being treated for narcotic addiction with methadone we are sometimes unable to “promote the good in every patient.” If we can not verify that the patient is in a licensed methadone clinic we are forced to let the patient go through withdrawal. As a pharmacist, you are responsible for providing the best possible care for the patient but in this situation that ability is being withheld.
By doing nothing, we are also violating beneficence. Beneficence means to do good and often requires one to look at different views to determine who benefits. The inability to verify that the patient is in a treatment clinic equates to the patient not being able to receive their medication. This forces the pharmacist to do nothing. By not being able to do anything for that patient, we are violating beneficence.

The unethical aspect of these laws also violates justice. Justice in the realm of ethics means fairness. This rule is unfair to those patients. The symptoms of withdrawal can be severe and can vary between patients. Symptoms include: elevated body temperature, pulse rate, blood pressure, and respiratory rate. Furthermore, evidence of narcotic abuse is found in some of the patients that are admitted to the hospital. It is unfair to make these patient's suffer when there is a known and effective treatment.

This law also violates deontology and ideology. Deontology and ideology dictates that everyone should be served equally. The law prevents all patients from being served equally because some patients are not able to receive their methadone. It is not the patient’s fault that the facility is closed when they are admitted to the hospital.

This law forces some patients to go through withdrawal and makes the patient experience cravings for narcotics. Supportive care can be provided but is aimed at only treating the symptoms of withdrawal and does absolutely nothing for the cravings. Benzodiazepines are often given as supportive care but if the symptoms are severe they may not be enough. This can be very scary because there is no telling what the patient will do if the patient is released from the hospital having not received any methadone for a day or two. The patient could be at risk for experiencing a relapse. Methadone is relatively safe and is much safer than the street drugs that these patients may possibly seek.

The patient should not be punished because their respective treatment clinic is closed. The law needs to be changed to allow an exception for these patients and allow up to a two day emergency supply. Patients who claim that they are in a treatment clinic should be given the benefit of the doubt and allowed to receive methadone until the pharmacist can verify that the patient is being treated in a treatment clinic. If the patient is not in a treatment clinic, then the methadone can be discontinued immediately without any harm to the patient. If in fact the patient is in currently receiving treatment, you can verify the dose and continue to treat the patient while they are in the hospital.

Another option would be to create a database similar MAPP where pharmacists can access the proper information needed to initiate methadone therapy twenty-four hours a day, seven days a week. This would eliminate the need for the emergency supply and ensure that the patient is receiving the correct dose. However, this would be difficult to implement because it would
require the patient’s information to be entered into the database and require constant updating to ensure the most accurate information.

Another issue is that it is unethcical to allow a patient to remain on methadone for two years and beyond that if deemed medically necessary by a physician. There is a possibility for patients to become addicted to methadone as well. By allowing patients to remain on the medication for a long duration of time, you are putting the patient at risk for becoming dependent upon the methadone. Furthermore, after long time treatment, patients are watched as closely once the clinic deems that the patient is not at high risk. These patients are not forced to go to the treatment clinic everyday.

In this situation, the law violates nonmalificence. If we do nothing we are not in violation. However, by acting and doing harm, we violate this principal. For some individuals, two years maybe necessary to ensure that the patient is drug free. However, by allowing some patients to remain on methadone, we are possibly exposing them to methadone addiction. Especially sense these patients already demonstrated addictive behavior.

A change to a law in treating substance abuse is difficult to obtain. There is still a stigmatism associated with substance abuse. As result these patients are often not treated with the respect and dignity that they deserve.

At the hospital where I intern, I have seen this first hand. In one instance, a pharmacist was notified that a patient was in a methadone maintenance treatment clinic. The nurse then told the pharmacist the name of the clinic but there are multiple sites and the nurse was not which location. The pharmacist requested the nurse to find out which specific location. When the pharmacist hung the phone up, the pharmacist stated that by the time that the nurse called back the clinic would be closed. The patient would have to wait until tomorrow.

In another instance, a patient was admitted to the hospital from the nursing home. When obtaining the medication history, it was discovered that the patient was on methadone for narcotic addiction. However, the patient was not in a treatment clinic. The doctor at the nursing home was prescribing the methadone which is illegal. The patient was not allowed to receive methadone in the hospital. The pharmacist referred to the patient as a “junky” and was glad that the patient did not receive the methadone.

To get an idea of the feelings of my fellow student pharmacists as well as a few of my preceptors, a survey was conducted. A total of 24 pharmacy students and 3 pharmacists were surveyed. All of the pharmacy students currently intern in the community setting and only the 3 pharmacists have hospital experience. The survey provided a brief explanation of the current law. It particularly addressed the inability to provide methadone to patients in treatment clinics until after a pharmacist has verified that the patient is in an approved treatment clinic. The following charts display the results of the survey.
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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Is the current law fair to our patients?</td>
<td>23</td>
<td>4</td>
</tr>
<tr>
<td>Does the law violate the pharmacist’s code of ethics?</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Does the law violate your personal code of ethics?</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>Should there be a stipulation for an emergency supply when patient enrollment can’t be verified?</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>If an emergency supply was permitted, should pharmacists be allowed to exercise their professional judgment in granting an emergency supply?</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>If it were legal, would you dispense an emergency supply to a patient?</td>
<td>10</td>
<td>14</td>
</tr>
</tbody>
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The participants were also asked which of the following influenced their decision. Those surveyed were asked to select all that apply.

<table>
<thead>
<tr>
<th>Influencing Factor</th>
<th>Frequency (n=27)</th>
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<tbody>
<tr>
<td>Religious/cultural beliefs</td>
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</tr>
<tr>
<td>Personal beliefs about addiction</td>
<td>18</td>
</tr>
<tr>
<td>Pharmacist’s code of ethics</td>
<td>12</td>
</tr>
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</table>
The overall results of the survey indicate that many people do not feel that the current laws are unethical. The results also show that most of those surveyed feel that the current laws do not violate the Pharmacist’s Code of Ethics or their personal code of ethics. In addition, a majority of those surveyed did not feel that the law needed to be adjusted to allow an emergency supply. Furthermore, if it were allowed they would not feel comfortable dispensing methadone until after verifying that the patient is in a treatment clinic. In addition, the biggest influence on their responses was their personal beliefs on addiction. The surveyed individuals also considered their own personal ethics as well as the pharmacist's code of ethics when forming their responses to the questions asked.

The fact that the major factor influence on individuals in forming their responses was their own personal belief was alarming. This confirmed that there is a stigmatism surrounding substance abuse. This was further evident by some of the comments that were provided by individuals. One individual when asked why they thought that current law is fair to our patients stated “so that heroin addicted patients won’t just go into hospitals to get a “fix” by abusing the system.” Another individual stated that “we can’t have a bunch of heroin addicts running around.”

When asked why to some of the questions on the survey, there were a variety of answers. One individual felt that methadone was highly abused. Another individual stressed that they felt that the many of the treatment clinics are not run properly and that most methadone treatments are not supervised properly. It was also stated that “if you take methadone with a benzodiazepine you achieve a euphoric high.”

There are some flaws to the survey that was conducted. First, the number of individuals that were surveyed. Only 27 individuals were surveyed. The results of the survey can not necessarily represent the feelings of every pharmacist or student pharmacist. The survey was voluntary, only three pharmacists and twenty-four student pharmacists opted to participate.

Second, the results of the survey could have been skewed due to the lack of knowledge of the methadone laws. The majority of the individuals surveyed were student pharmacists. This aspect of methadone and the current laws were not discussed in depth in class.
Third, the area of practice could have influenced their responses to questions. The majority of those surveyed interned in the community setting. Some of the interns responded that they dispense methadone in their pharmacy. I do not think that some of the interns understood that the methadone for treatment of narcotic addiction is supposed to only be dispensed through a licensed treatment facility.

The results of the survey were not expected and were the complete opposite of what was expected. The survey results were completely contradictory of the arguments of this paper. However, some participants felt that the law was unfair and felt that it should be changed. One individual stated that an emergency supply of methadone should be allowed because “it will help our patients.”

In Conclusion, some aspects of the current methadone laws are unethical and violate the pharmacist’s code of ethics. Changes to the law should be made to allow pharmacists to better serve our patients. However, as demonstrated by the survey, some feel that this is not a problem. The stigmatism surrounding substance abuse as well as individuals’ personal beliefs about addiction are the driving influence regarding individuals’ feelings about the current law. In addition, it will be very difficult to get support to change the current law to allow an emergency supply and put stricter rules on the duration of stay allowed in a program.
References


5. (Vivian, Jesse. Lecture. 26 Sept. 2005