

David Caraway: Methadone should be temporary treatment option only

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I read with interest the comments of Gen. Barry McCaffrey, a paid adviser to CRC Health Group, which operates a methadone clinic in Huntington, and of CRC CEO Barry Karlin published in The Herald-Dispatch on Feb. 15 urging West Virginia lawmakers to embrace methadone clinics.

The information supplied is not balanced or complete.

Methadone maintenance was described as being a safe and efficacious method for treatment of opioid addiction. McCaffrey stated that methadone programs "... can get many people addicted to maintain sobriety."

What has not been clearly communicated to the customers of these clinics, to lawmakers and to the general public is that methadone maintenance as provided by CRC and similar for-profit centers is primarily a drug substitution and distribution program.

Methadone is a potent opioid meaning that it has a mechanism of action very much like heroin, oxycodone, morphine and hydrocodone -- with similar abuse and dependency characteristics. Methadone is used in these clinics because it is cheap, long-acting and can be delivered orally as a single daily dose.

However, there is emerging evidence, including recent FDA warnings, that this drug may have unique risks associated with its use, including sudden cardiac death and unpredictable accumulation in the tissues of the body with resultant lethal interaction when used with other medications. West Virginia has gained international notoriety for opioid abuse and in recent years has led the nation in deaths due to methadone abuse.

Methadone is sold legally by methadone clinics to individuals addicted to methadone, heroin, oxycodone or other opioids. Ultimately, the client usually remains physically dependent on the drug but the behavioral aspects of addiction may be modified.

Good studies demonstrate that, especially when used to treat heroin addiction, long-term stabilization of methadone dosing can be achieved with improved societal economic impact. While this may well be a desirable goal, methadone maintenance does not free an addict from opioid dependency, has risks and is not uniformly effective.

Certainly, there is a financial incentive for methadone clinics to continue to dispense methadone rather than work toward opioid abstinence. This should be clearly understood by Legislature. Some states limit the amount of time an addict may remain on methadone maintenance. The goal is to gradually reduce the dose until the addict is off of all opioids. There are many sound clinical reasons why this should remain the goal. Unfortunately, multiple relapses are common. The frequency of ongoing drug abuse while receiving methadone treatment is also significant.

Methadone treatment centers play a role in helping opioid addicts improve the quality of their lives and may reduce drug-related crime and the economic burden of opioid drug abuse. Lawmakers must ensure that these centers have appropriate guidelines to prevent diversion of the dispensed methadone, monitor clients for ongoing illicit drug abuse, employ well-trained staff, and maintain the ultimate goal of abstinence from all drugs of abuse.