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TESTIMONY OF REPRESENTATIVE LAWRENCE E. LOCKMAN

(DISTRICT #30)

IN SUPPORT OF L.D. 802

An Act To Encourage Alternative Forms of Treatment for Opiate or Opioid Addiction by Prohibiting MaineCare Coverage for Medication-assisted Treatment for Addiction

Date of Public Hearing: Monday, May 13, 2013

Good afternoon Senator Craven, Representative Farnsworth and members of the Joint Standing Committee on Health and Human Services, I am Representative Lawrence E. Lockman. I represent House District 30 - beautiful Downeast Maine, 21 towns and 4 townships stretching from Pembroke, Dennysville and Edmunds on Cobscook Bay in Washington County to Amherst, Aurora and Great Pond in the Hancock County Highlands. As the sponsor of LD 802, I'm here today to speak in support of its passage.

This bill terminates MaineCare coverage or reimbursement for methadone treatment of drug addiction, effective January 1, 2015.

I want to begin by briefly reviewing some history on this subject. Rene Ordway's recent column in the Bangor Daily News is a good place to start that review. She wrote:

"Perhaps it's a good time to ask the question.

What has the presence of three methadone clinics in Bangor done for the city?

District 30 Alexander, Amherst, Aurora, Beddington, Cooper, Crawford, Deblois, Dennysville, East Machias, Eastbrook, Franklin, Great Pond, Jonesboro, Mariaville, Marshfield, Meddybemps, Northfield, Osborn, Pembroke, Wesley and Whitneyville, plus the unorganized territories of Centerville Township, East Central Washington (part, including Cathance, Edmunds and Marion Townships), East Hancock (part), North Washington (part) and Northwest Hancock

In 2000, when the community was struggling with whether to allow one clinic to open, residents attending crowded community forums were told that a clinic could reduce heroin use by 70 percent and decrease crime by 56 percent.

Instead, drug-related crimes in Bangor increased from 154 in 2010 to 237 in 2011, according to reports in the Bangor Daily News, and violent crimes increased by 35 percent in that span. In 2000, 60 people died of drug overdoses in Maine. In 2009, that increased to 179, the BDN reported.

In 2010, Bangor had the highest crime rate in the state, nearly triple the statewide average, according to the BDN.

A recent story in the BDN revealed the state spends \$7 million in transportation costs getting methadone clients to the nine clinics around the state.

That's just \$2 million less than the state pays for the entire methadone program.

Officials will quietly acknowledge the abuse going on. Four people from northern Maine sharing daily rides to a Bangor clinic, yet charging the state separately for their mileage, for example.

The client living with her boyfriend in Bangor, yet charging the state daily round-trip mileage from her parents' home 75 miles away.

But those examples are apparently just the cost of doing business and, though acknowledged as a real problem, have no solution.

That \$7 million figure should not be met with a hapless shrug. Someone should be pounding a fist on a legislative conference table somewhere and insisting that something change..."

BDN 3/30/13

Fellow legislators, I am here this afternoon to metaphorically pound my fist on this legislative conference table, and insist that we re-think how state government deals with the epidemic of drug addiction.

That means we will have to challenge some entrenched special-interests, and some entrenched ways of thinking about addiction.

I will confess right up front to being a heretic. I do not subscribe to the prevailing orthodoxy that drug addiction is a disease. Those of you who do subscribe to the disease model should understand that your theory is just that, a theory. It is not a self-evident truth. In fact, the disease model is a relatively recent invention, first proposed about 40 years ago. I submit to you today that this theory should be discarded. And I would suggest that you randomly survey your constituents for their opinions, and see how many of them think treating drug addiction as a disease makes any sense. It seems to me that we have a lot more drug addiction since we started treating it as a disease.

Lance Dodes, M.D., is an assistant clinical professor of psychiatry at Harvard Medical School. In a recent article, here's how he described the divergent schools of thought on addiction:

Let's start with a short history. In the bad old days, before the disease concept became widely popular (about 40 years ago), our society was even more prejudiced against people with addictions than it is now. "Addicts" were seen as different and worse than "normal" folks. They were thought to be lacking in ordinary discipline and morality, as self-centered and uncaring. They were seen as people who were out for their own pleasure without regard for anyone else. They were viewed as having deficiencies in character.

Then came the idea that addiction is a disease: a medical illness like tuberculosis, diabetes or Alzheimer's disease. That meant that people with addictions weren't bad, they were sick. In an instant this changed everything. Public perceptions were less judgmental. People were less critical of themselves. Of course, it wasn't welcome to hear that you had a disease, but it was better than being seen as immoral and self-centered. So, the disease concept was embraced by virtually everyone. With all its benefits, it's no wonder this idea continues to attract powerful, emotional support.

Widespread enthusiasm for the disease model, however, has led to willingness to overlook the facts. Addiction has very little in common with diseases. It is a group of behaviors, not an illness on its own. It cannot be

explained by any disease process. Perhaps worst of all, calling addiction a "disease" interferes with exploring or accepting new understandings of the nature of addiction.

This becomes clear if you compare addiction with true diseases. In addiction there is no infectious agent (as in tuberculosis), no pathological biological process (as in diabetes), and no biologically degenerative condition (as in Alzheimer's disease). The only "disease-like" aspect of addiction is that if people do not deal with it, their lives tend to get worse. That's true of lots of things in life that are not diseases; it doesn't tell us anything about the nature of the problem....

But if we are to scrap the disease concept and replace it with something valid, our new explanation must retain all the beneficial aspects of the old disease idea. It must not allow moralizing or any other negative attributions to people suffering with addictions. In fact, we'd hope an alternative explanation would have more value than the disease label, by giving people with addictions something the disease concept lacks: an understanding that is useful for treating the problem.

Knowing how addiction works psychologically meets these requirements....When addiction is properly understood to be a compulsive behavior like many others, it becomes impossible to justify moralizing about people who feel driven to perform addictive acts. And because compulsive behaviors are so common, any idea that "addicts" are in some way sicker, lazier, more self-centered, or in any other way different from the rest of humanity becomes indefensible....

Despite all its past helpfulness, then, we are better off today without the disease idea of addiction. For too long it has served as a kind of "black box" description that explains nothing, offers no help in treatment, and interferes with recognizing newer ways to understand and treat the problem.

And there is one more advantage. If we can eliminate the empty "disease" label, then people who suffer with an addiction can finally stop thinking of themselves as "diseased."

"Is Addiction Really a Disease?" Published on December 17, 2011 by Lance Dodes, MD, in [The Heart of Addiction](#)

So there you have a brief history of how methadone treatment was sold to Maine taxpayers, and a critique of the disease model of addiction from a Harvard Medical School professor. I would respectfully suggest to you

that all we have done is substitute one addiction for another. And make no mistake, methadone is a highly addictive drug.

Two years ago the Bangor Daily News published a lengthy story about 24-year old Amanda Higgins of Trenton and her battle against Oxycontin addiction. Here is an excerpt from the story:

After two years of traveling to the Bangor Metro for her daily [methadone] dose, Higgins decided she no longer wanted to be a drug addict. She started in November 2008 at 20 milligrams of methadone and went up to 70 milligrams at her peak.

Over several months in early 2010 she decreased her methadone intake until she got down to 5 milligrams . On Aug. 1, 2010, she took her last shot of the cherry-flavored liquid painkiller.

"I stopped and it was the worst three weeks of my life," she said. Her methadone withdrawals "felt like I had really bad flu. It was bad."

"When you kick pills [Oxycontin] you got maybe seven days [of withdrawals], but after the fifth day you start feeling better," Higgins added. "With methadone it doesn't subside. For three weeks there is no sleeping, your body won't let you, and your skin crawls. That's the worst."

After her withdrawals subsided, Higgins joined Narcotics Anonymous and got a sponsor. She now attends meetings at least three times a week.

"That really saved my life," she said. "It's an amazing program. I can talk to my sponsor about anything. She has provided me a support system."

Bangor Daily News 2/25/11

To sum up, let's face the fact that the methadone clinics have failed to reduce the crime rate as promised. In fact, just the opposite has happened. And while Maine's population has remained flat, the number of people in treatment has exploded, from 2,400 MaineCare recipients on methadone in 2008 to 4,200 in 2012.

Two years ago this committee heard testimony from addicts who freely admitted they are moving here from other states. And with rare exceptions, they never seem to move out of treatment. Isn't it reasonable to ask: does perpetual treatment ever result in recovery?

In closing, I would ask that each of you bear in mind that we are borrowing money from our grandchildren – that would be the federal funding of MaineCare – to pay for highly-addictive drugs, and cab fare to transport the addicts to the clinics where the addictive drugs are administered. Meanwhile, we have seriously disabled people with traumatic brain injuries, people who cannot feed themselves, who qualify for MaineCare, but are on waiting lists because funding is not available for them.

This did not happen by accident. This choice to include some and exclude others was the result of decisions made by Maine's state government of which we are the elected legislative branch. I submit to you that a society with its priorities so skewed is a society with a death wish.

LD 802 is more than a wake-up call. It is shock treatment.

I urge you to send it up to the third floor with a unanimous “ought to pass” report.

Thank you for listening.