

# Methadone Today

The official newsletter of DON'T--BY PATIENTS, FOR PATIENTS February 2002 Volume VII Number I

## Our Common Bond

by A. C.

No matter how much people disagree about various topics, there are always certain common bonds that we all share. As addicts, methadone patients and recovering people, we can all say with complete conviction that we know what it means to be so close to death that we could almost smell the foul breath of the grim reaper sneaking up behind us at any given moment.

There is a familiarity between patients that I could never fully describe. It's as if we can just glance at one another and instinctively know what the other is feeling. It is this familiarity that keeps some people around at times. I have seen on many occasions when someone is ready to run out the door because of some disagreement or conflict with someone, and it is always one of US that stops them and says: "hey, slow down, I have been there..." I remember being that person heading for the hills, and I will tell you what stopped me time and time again.

It was YOU that kept me here. At a time when I was dragging my ass to the clinic in the morning still feeling my last shot, it was your smile that made me think there was another life for me. If you don't know why I am referring to you here, think for a second. Think about the times you stood in line and talked about your take homes and how thankful you were that you had finally received them. Think about the reassuring look you gave me when I could barely keep myself in an upright position. You must remember the groups we sat in together when you kept tapping me on the leg to wake me up, and I would look at you with annoyance but also with gratitude. Maybe you can't remember these things because they didn't seem like much, but I just want you to know that they meant a lot to me.

I am sure glad I finally found someone like you because I was starting to think that you were all like this other person I know. I am sure [this person] doesn't even realize that he had an impact on me. The person who stood in line with me and looked down on me with disgust when I couldn't keep my eyes open probably doesn't know that I did see those looks from behind my heavy eyelids. I not only saw them—I felt them. I remember sitting in groups with this person and feeling my face turn red when he would refer to the junkies who were "taking up space and had no desire to get clean." The time I was really humiliated was when he actually announced out loud that he couldn't stand being in the same room with **(Cont. p. 3)**

## Maintenance

[The following is reprinted from the handbook, "About Methadone," published by The Lindesmith Center-Drug Policy Foundation.]

Methadone maintenance is intended to do three things for patients who participate:

- 1. Keep the patient from going into withdrawal.** The standard initial dose, as currently recommended, is 30 to 40 milligrams a day. After several days, providers adjust a patient's dose as needed.
- 2. Keep the patient comfortable and free from craving street opioids.** Having a craving means more than just having a desire to get high. It means feeling such a strong need for opioids that people may have regular dreams about using drugs, think about doing drugs to the exclusion of anything else, and/or do things that they wouldn't normally do to get drugs.

Methadone won't control a person's emotional desire to get high, but an adequate dose of methadone should prevent the overwhelming physical need to use street opioids.

## Deadline for Methadone Clinics Approaches

*\*Quotes, facts from Lindesmith-DPF 12/6/01 e-Newsletter, "SAMHSA APPROVES*

### *METHADONE TREATMENT ACCREDITATION"*

Clinics have until March 4 to apply for certification to one of the accreditation agencies. As reported in past issues of **Methadone Today**, the new federal regulations require all OTPs\* to seek and receive accreditation from a SAMHSA authorized accreditation organizations. "The four organizations authorized... to accredit methadone maintenance providers are the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation of Children and Family Services, and the State of Washington Department of Social and Health Services Division of Alcohol and Substance Abuse." Patients may want to notify their treatment providers to ensure that they are aware of this requirement.

"The Center for Substance Abuse Treatment is providing technical assistance to methadone maintenance providers who have questions regarding the accreditation process. Questions about technical assistance should be directed to 1-800-839-6120. Questions about federal regulations or the federal certification process should be directed to 1-866-463-6687."

It remains to be seen whether the accreditation system is truly a serious improvement over the past system, whereby treatment providers had to be specially licensed by the FDA. Proponents of this accreditation system predict great benefits in the form of better quality treatment, resulting in reduced stigma and discrimination against methadone maintenance patients. An alternative prediction is that it will be no better or norminally superior to the FDA licensing scheme; or worse, that it will increase cost and accountability by adding another layer of bureaucratic regulation (instead of the regulating being handled by one organization [the FDA, a government agency], regulatory duties will be divided between SAMHSA [a government agency] and the aforementioned accreditation organizations [private entities which tend to be less accountable]). Also of note is a serious limitation of this accreditation system: states are still free to set their own additional rules and regulations. Excessive state regulations are arguably the greatest challenge to treatment quality and accessibility.

\*OTPs (opiate treatment providers) refers to methadone clinics.

**3. "Block" the effects of street opioids.** If the dose is high enough, methadone keeps the patient from getting much, if any, effect from the usual doses of street opioids. The result is often called the "blockade" effect.

If a person's opioid tolerance is elevated high enough with methadone treatment, a great deal of heroin would be required to overcome it and produce a significant high.

**Editor's Note:** As the above demonstrates, determining what is an adequate dose is a little more involved than one might think. Even determining whether withdrawal is an issue is not entirely straightforward. Relatively mild withdrawal is not necessarily apparent to physicians.

Even when symptoms of withdrawal apparently cease, opiate cravings may persist. Clinics where a "lower is better" dosing philosophy prevails are likely to be dismissive of patients with cravings but no outward withdrawal symptoms. Whenever a patient continues using illicit opiates, dose adequacy should be carefully considered.

## Patient Outcomes in Clinic vs. Office-Based Treatment--Trial Results

by Dr. Andrew Byrne, General Practitioner (NSW, Australia)

*\*Methadone maintenance in primary care: a randomized trial. Fiellin, O'Connor, et. al. JAMA (2001) 286:1724.*

For the first time a randomized study\* has shown that "stable" methadone patients treated in the clinic setting fare no better than those given office treatment by private doctors (and there are numerous benefits in private treatment). This is just as important in America as elsewhere where methadone is often administered by community pharmacists on prescription from regular doctors.

There were 40% to 50% of patients in each group who used illicit drugs during the trial with no significant difference between groups. About one-half of these relapsed patients were considered "clinically unstable" in each group. However, there was a spectacular difference where fully three-quarters (75%) of the office-treated patients stated that the quality of their care was "excellent", a rare compliment in this field. In comparison, a dismal 13% of clinic patients felt their treatment was "excellent".

It is gratifying to find that what many of us have been doing for 20 years is now proven safe and effective by careful research of this nature--and so these researchers are to be congratulated. I wonder if such a comparison was done for hypertension, diabetes or cholesterol treatments before they were introduced into office-based practice. Patients are usually permitted to benefit from new medications as soon as they are approved... that is, unless the drug is for addiction treatment. The same nonsense is going on at present with buprenorphine, a drug which we know from good research is immensely safe and very effective in a variety of clinical settings. [*Editor's Note: An exception to the previous statement: U.S. doctors may be permitted to provide buprenorphine treatment out of their private offices with few rules and restrictions--even to new patients; doctors will be able to prescribe supplies of buprenorphine to be taken at home on an unsupervised basis*]. And WE are getting positive results in Australia after a year of general use for addiction, with mostly supervised administration.

A major flaw with this study\* of office-based practice is that the standard of treatment given to the patients was not documented. However, a table giving dose levels would appear to indicate inadequate doses in general. Clearly those with adequate methadone dose levels are more likely to do well in any setting. It appears that in regular ongoing maintenance there are many more problems with underdosing than overdosing. D'Annunzio has documented that a high proportion of American clinic patients are given inadequate doses, and this may also apply to office-based treatment elsewhere as in the UK and Australia. The average dose in Dole's first trial was reported as 103 mg daily.

[*Note: Dr. Dole, along with Dr. Nyswander, conducted the very first methadone maintenance trials--Dr. Dole is still highly regarded and considered "the father of methadone maintenance."*] It may be that if the criterion for transfer to an office-based treatment setting were related to the documented standard of treatment, then the results of drug testing may have been more consistent (and negative!).

**Editor's Note:** We find it difficult to believe that any physician who is knowledgeable and highly experienced in the field of maintenance treatment would truly believe that clinics provide superior treatment to private physicians in an office-based setting--at least when it comes to stable patients. If those who oppose allowing stabilized methadone maintenance patients to receive treatment from private physicians were being honest, many of them would acknowledge that their position has little to do with quality of care and the best interests of patients. Many opponents of OBOT (office-based opiate treatment) have either political or financial motivations for their position.

In truth, the primary reason for severely restricting or banning OBOT is "diversion control". Despite there being virtually no evidence--even anecdotal--that making OBOT available to stable patients would even slightly increase the amount of methadone diverted to the black market, the DEA and some policymakers have opposed OBOT. When the new federal regulations were proposed, the accompanying comments all but acknowledged that many of the proposed rules/requirements were written to limit diversion of medication. In these comments, it was suggested that buprenorphine treatment when approved would most likely be subjected to fewer, less stringent regulations purely because it is believed to be less prone to diversion--supposedly buprenorphine would be less desirable for non-medical use/abuse, particularly when it is combined with naloxone [an antagonist] to discourage injection use.

The U.S. government will be requiring that the buprenorphine is combined with naloxone, but a recent study of this combo\*\* calls into question whether naloxone would really discourage injection use [\*\*see p. 2 of the July 2001 Issue of *Methadone Today*, "Recent Study into Buprenorphine-Naloxone Combo Raise Questions of Safety, Ethics" by Dr. Andrew Byrne]. Perhaps this study\* will finally put to rest the argument that only licensed/accredited clinics can provide quality maintenance treatment. From this study, it is apparent that stable patients do not benefit from highly supervised and restrictive clinic-based treatment. As Dr. Byrne points out, there are many advantages to office-based treatment. To begin with, there is less of a stigma attached to being treated at a doctor's office than a methadone clinic. If the welfare of patients is to be the most important consideration, office-based treatment is clearly superior for stable patients.

One final comment--we concur with Dr. Byrne's keen observation that the methadone doses provided in the study\* were probably inadequate for many of the patients. We are utterly disgusted by the large number of American methadone maintenance research studies where many of the patient participants are obviously under dosed. Dose adequacy has repeatedly been demonstrated to be hugely important to treatment success; thus, the provision of inadequate methadone dosages will obviously skew the results of such studies. Even taking into account that [according to Dr. Byrne], "about one-half of these relapsed patients were considered 'clinically unstable'," the percentage of patients using illicit drugs certainly would have been significantly lower if the patients had been adequately dosed. Besides skewing the research results, [as Dr. Byrne has pointed out in the past] providing sub-optimal dosages is an ethically questionable practice--this is true in general, but arguably more so in a research study. We hope to see follow-up research into office-based treatment, where adequate dosages are utilized.

**Our Common Bond (from p. 1).**

someone who was so obviously wasted and couldn't keep her eyes open for even one hour. I guess he didn't realize that I was struggling with staying clean and that the methadone didn't seem to be doing anything for me. Maybe he didn't know that I had just spent last night and the previous ten years of my life on the street, and I had no idea how to relate to people who weren't getting high. Maybe if that person had known that I was still selling my ass every day to get by, they would have gone a little easier on me.

I knew that I was different than these people. They obviously had it easier than I did because they were all clean and I just could never imagine me being clean for one hour let alone one year. Then I realized that they were all probably lying. After all, junkies don't get clean. Everybody knows that. Sure, I did think that their smiles looked real and they did appear healthy, but they all have to be using on the side, right?

Sitting in that group that this clinic made me go to only reaffirmed the fact that there was no hope for me. I couldn't even fake it like these people so obviously were. It was really difficult to focus on anything because the ache in my back and the chill up my spine would remind me every time. I guess these people are really stupid too because they actually think I am high when really I am feeling like I want to die.

That lethargic feeling always preceded the sickness and the bullshit methadone barely did a thing to make me feel any better. I was barely hanging on yesterday, and now today I feel even worse.

When is this stuff going to start working anyway? Those nurses keep telling me to give it time, and my counselor can't imagine why I won't stop using. She keeps telling me that I must not have the desire to get clean. Maybe she thinks I ENJOY the life I lead? Laying down with some stinking guy and letting him do whatever he wants to me so long as he pays for it is not exactly my idea of a good time.

My life has boiled down to one constant truth. I need to do whatever I can whenever I can in order to make some money to buy dope. Maybe this lady sitting across from me in her clean suit and manicured nails thinks I like sleeping on dirty mattresses crawling with lice. After all, I guess I can see why she thinks I have no desire to get out of this place I am in. Who would want to leave this? The throbbing pain I have come to know as a constant companion from the bleeding abscesses on my arms would be hard to give up. Not to mention the infections and illness and CONSTANT TERROR.

I guess I sound angry. I do realize that I have no right to be angry with anyone else considering I am the one who put myself in this position. I am the one who chose to stick needles in my arms and therefore, I have to

pay the price for my actions. What I can't get out of my head however is WHY I chose to do all this to myself. Even more importantly, why do I keep doing it? Why don't I just stop? I guess I will never know....

So, I come to this clinic everyday and drink this stuff that doesn't do a thing, and every so often I get to hear how I am taking up space. This morning I was handed a letter saying I have thirty days to stop using or else I have to find another treatment program. They say that I am just not ready for treatment since I consistently submit "dirty" urines. I want to laugh when I read that because I just find it so ridiculous that they expect me to give clean urines. Do they REALLY think they have offered me a viable alternative to my lifestyle?

So, I stand here in line once again and try to remain upright and YOU walk in with that smile and that walk of assurance. I even start to think that you really are clean and not just lying like all those other people in my group.

When you asked me how I was feeling, I could see that you really wanted to know and weren't just making conversation. Rather than just giving my standard answer of "okay", I open my mouth, and it's as if the floodgates have opened. Through my tears I explain that I am just barely hanging on here and that I cannot understand how I am supposed to stop using.

Then you asked me that question that nobody had ever asked me before. It threw me a little because I didn't think that the answer really made a difference. When you asked me what dose I was on, I assumed you were just curious. I told you that I was on the forty milligrams that the clinic started me on. That was the amount that they said would hold me, and I didn't think to question it since they are the professionals, and they know more than I do.

Not one second after the words, "forty milligrams" come out of my mouth, I saw the corners of your mouth start to turn up and a twinkle in your eyes. I just assumed that you were going to laugh at me for thinking I was sick when I was obviously getting a dose that should suit me. When you put your arm around me and said, "I think I can help you," I really felt that I had just been taken under your wings, and for the first time in a very long time I felt a sense of hope.

For hours I listened to you open up a whole new world to me. I listened to you talk about optimal dosing, clinic abuse, state and federal regulations, and uneducated and misinformed clinic staff, and though much of what you said was a little over my head, I heard you, and I was amazed....

I never in a million years thought that my problems were dose related. I just assumed that I was different than everyone else. You told me that I had a disease and that it wasn't my fault that I was the way I was. I finally had the answers to all those questions I used to ask myself. I knew that I didn't do this

to myself.

The people who I thought were lying about being clean had also found salvation in a proper dose of methadone and were really doing well. It is the nature of addicts to assume that when they are doing poorly, everyone else is as well. Though, when I asked why those people had treated me with such disrespect, you said it was simple. They had done what so many addicts do after a little time clean.

I found out that you were really clean and had been so for a very long time. You didn't make a deal with the devil, you didn't have to attend shrinks, meetings or go away for long periods of time. All you did was educate yourself. You found out what worked for others and tried it that way. You met other people on methadone and began working to make things better for all of us. You work with patients, clinic staff, doctors and legislators. You attend conferences and spend countless hours online researching and sharing ideas with other people just like you. You devote your life to us and for that I am grateful. When I told you that you were a true angel, you modestly said, "No, I am just an advocate trying to help others. Now you can repay me by helping someone else."

And so, here I am months later on triple the dose I was on when I came in, and my life has changed so dramatically. I am off the streets and living in a real home for the first time in over a decade. I have my own family now and have repaired much of the damage I had done when I was sick. I work now at a real job and I am able to support myself and family doing something that makes me feel worthwhile.

However, those are just the physical changes. More importantly, I can look in the mirror and smile, for I finally like the person looking back at me. I can close my eyes at night and know that in the morning I will wake up in my bed and not feel the horror of dope-sickness. Through my ability to feel good physically and have that area of my disease handled, I have begun to work on the things inside of myself that have been damaged by my disease. I am growing and changing every day, and I have truly come back to this world reborn.

Now, once a week when I stand in line for my medication and my take homes, I look at all the faces around me and try to focus on the ones showing the most pain. Amidst all the activity and conversation, there is always that one beaten soul who can barely manage to speak. It is that person that I will focus my attention on and ask, "So, what dose do they have you on?"

I know I can't help everyone and some days, I can only help myself. However, I am hopeful that I can do for another what was so freely done for me. I am hopeful that one day through me, another advocate will be born, for that is how we keep this thing going. One cause at a time, one battle at a time... one patient at a time....

## Dear Methadone Today,

I enjoy reading your newsletter. I have been a methadone patient for four years and have turned my life around in this program. I also go to AA and a psychologist. With the support of my doctor, I have rejoined the work force. I hope to start dating soon—with some luck, even have a relationship again.

I do know all this will take time, and I know from the past that I have to take my time. But my biggest fear is relapse. I've seen people leave the clinic and in no time, they are back, and they all say the same thing, "I shouldn't have left so soon." I don't want to make that mistake. **-C.B.**

## Dear C.B.,

I'm glad to hear you're doing so well. You are wise to learn from others' mistakes regarding leaving treatment too soon. You should NOT withdraw from your medication until "you" are ready. A common mistake patients make is allowing their families, significant others or counselors to make this decision for them.

The relapse rate for patients who quit taking methadone is astronomical. Upwards of 80% of those methadone patients who quit taking their medication relapse to daily opiate use within a short time. With the threat of injecting drug users contracting Hepatitis C and AIDS, there should be no doubt in your mind that you, and only you, feel you are ready to discontinue this life-saving medication. If you are never ready, there is nothing wrong with that.

## NOTICE: CAP Opens a Facility in Maine

CAP (Center for Addictive Problems) recently opened a clinic in Maine, where we understand that quality and affordable treatment were sorely lacking. Marc Shinderman, M.D., the Owner/Medical Director of CAP, is on **Methadone Today's** Medical Advisory Board. **Methadone Today** and many of CAP's patients, who rave to us about the excellent quality of care they receive, believes that CAP is among the best methadone treatment providers in the country. Dr. Shinderman was presented the first Illumination Award from the advocacy groups at the AMTA conference in recognition of this fact.

We are providing the information below for the benefit of current or prospective patients who might be interested in obtaining treatment from what we have found to be an excellent provider. Thus, below is the relevant information for the new CAP

**Beth Francisco, Senior Editor**  
**Aaron Rolnick, Managing Editor**

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DON'T 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.**

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clinic in Westbrook, Maine, as well as for the other CAP facilities.  
To obtain maps or directions, call or send an e-mail to the facility.

## Center for Addictive Problems

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**E-mail:** [cap@capqualitycare.com](mailto:cap@capqualitycare.com)

**Fees:** \$55 wk.

**Hours:** Monday through Friday: 5:30 AM - 10:30 AM;  
12 Noon - 2:30 PM; and 4:00 PM - 7:00 PM  
Saturday: 8:00 AM - 2:00 PM  
Sunday: 9:00 AM - 10:00 AM

## CAP of Downers Grove

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**Hours:** Monday through Friday: 6:00 AM - 10:00 AM and  
12 Noon - 1:00 PM  
Saturday: 8:00 AM - 12 Noon; Sunday: Closed

## CAP Quality Care

**(\*Now open and located Near Portland, ME)**

**One Delta Drive, Suite A**  
**Westbrook, Maine 04092**

**Tel:** (207) 856-7227, (207) 856-7CAP, (800) 477-7CAP

**Fax:** (207) 856-2112

**E-mail:** [capmaine@capqualitycare.com](mailto:capmaine@capqualitycare.com)

**Fees:** \$85/week (for couples, \$160/week)

**Hours:** Monday through Friday: 5:30 AM - 10:00 AM and  
12 Noon - 1:30 PM

Saturday: 8:00 AM - 12 Noon; Sunday: Closed

**Directions:** One Block from Exit 8, off US 95  
Convenient and Ample Parking

To register for admission, transfer, or to obtain general information, contact an "Intake Coordinator." If a return call is requested, CAP personnel will speak only to the person who placed the call, preserving confidentiality, as is CAP's policy with all communication.

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- Donation of \$ \_\_\_\_\_ to send **Methadone Today** to someone who cannot afford it or to educate policy makers, clinic staff, medical personnel, etc.
- Enclosed are \_\_\_\_\_ 37-cent (or other) stamps to help with postage.
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Clinic Name \_\_\_\_\_ Clinic Phone \_\_\_\_\_