Methadone Today

The official newsletter of DON'T--by patients, for patients May 2002 Volume VII Number IV

Worrisome State Proposal Shelved

The Kentucky State Legislature recently considered legislation that would have placed excessive and dangerous rules and restrictions on the provision of opiate agonist (methadone) treatment (OAT). Among other provisions, this legislation would have created county boards that would have broad oversight and power over the opening and operation of OAT providers. The legislation mandated the composition of the boards, and one-half of the board members would be officials in law enforcement or the criminal justice system.

The many potential dangers of such a system are apparent—a board in which 50% of the members have no medical/counseling background whatsoever would make sweeping rules regarding the provision of opiate agonist treatment. The original version of the bill would have given these boards the power to deny individuals and organizations the right to even operate a facility in their county. If this were the case, it would be quite likely that methadone clinics would not exist in many areas of Kentucky.

Fortunately, this bill was defeated--in part, due to the efforts of patient advocates. But this bill is likely to be reintroduced at some point. Similar proposals may eventually be introduced in other states, where politicians hope to score points with voters by bashing methadone maintenance treatment.

The proposed legislation in Kentucky should serve as an alert to patients and patient advocates that just because the regulations were reformed at the federal level does not mean that it is smooth sailing when it comes to government policy—at least at the state level. There are still plenty of policymakers out there who have it in for methadone maintenance/opiate agonist treatment. In a worst case scenario, advocates of OAT may see a backlash to the adoption of the new, relatively progressive federal regulations. Those who strongly oppose OAT are likely to redouble their efforts at the state level to attempt to ensure that 30- or even 14-day take-home supplies are never permitted.

Therefore, advocates are going to have to concentrate on influencing policy at the state and local level. More methadone patients and their families need to get involved in advocacy—not merely out of altruism but for their own good. Being an advocate does not necessarily involve expending ***(Cont. p. 3)***

Dear Methadone Today,

I would like to thank you for the information you recently provided me about what to expect when traveling to foreign countries with my methadone take-homes. While I have not yet had time to take a vacation, it is nice to know that I would be able to go to Europe and the places I have always wanted to visit without worrying about being arrested or having my methadone confiscated at customs.

There is another issue where I would like to find out your readers' experience. Because I had not been a heroin addict or even more than a "recreational user" (weekends) for very long before I decided that I needed to switch to methadone. I had initially hoped to wean off of the methadone within less than a year, starting at 30 mg. Once I got stable at 30 mg, I got down to 10 mg after about 9 months of treatment, with 2 mg decreases every other week But then I messed up – I thought I could try some "recreational use" and got immediately re-addicted. I had to go back up to 20 mg to overcome that, and now I am afraid to reduce, even though I have learned my lesson–there is no longer any such thing as recreational use for me.

Now I am starting to feel confident enough to try to reduce again, and I want to know what other people have experienced. Is it better to reduce 2 mg every 2 weeks, or is one reduction per month more reasonable? Since the percentage that 2 mg represents gets to be a pretty big number when you get down to the 10 mg range (i.e., 10 mg to 8 mg = a 20% reduction), does it get harder than a 2 mg reduction from, say 30 mg to 28 mg?

When you get down to 4 or 5 mg, is that a low enough dose to just quit from there? I have heard about one person at the clinic who just went "cold turkey" from 10 mg, but I have no way of knowing how long he suffered. My normal reaction to the 2 mg reductions was that I would be uncomfortable (sweats, depression) for about four days, then my body would adjust, and I would feel "normal". However, since I am self-employed in a job that requires me to be very productive all of the time, I cannot take the chance of having the side effects of withdrawal affect my work.

I would very much like to hear about your other readers' experiences in reduction, and their, as well as your, recommendations. ***(Cont. p. 3)***

Your Other Doctors

Reprinted from the handbook, "About Methadone," published by The Lindesmith Center-Drug Policy Foundation.
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Methadone patients are sometimes reluctant to tell their other doctors that they are taking methadone. They are afraid that these doctors—or other health-care providers—will discriminate against them. Unfortunately, they are often right.

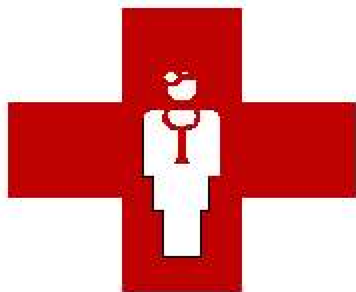
Find a primary-care provider whom you can trust. The ideal situation is to make sure all your doctors know that you are taking methadone. If you choose not to tell them, however, keep these important things in mind:

➤ If you are having surgery for which you may be put to sleep, the anesthesiologist might use a type of medication that will cause abrupt methadone withdrawal. Be sure you know which medications interact with methadone (see page 21-23 [of this handbook])—even if your doctors know that you are taking methadone.

➤ It is illegal for your methadone provider to communicate with your primary-care doctor or anyone else without your written permission. (Title 42 of the Code of Federal Regulations Part 2 [42CFR part 2] protects against disclosure of drug treatment records.)

Ideally, though, open communication among all the doctors who are treating you may assist you in getting the best-possible health care.

Notice: There will be no June issue of Methadone Today. The next issue will be published in July.



Determining Adequate Methadone Dose

Reprinted from **Addiction Treatment Forum, Vol. VI, #4, p. 3 Andrew Byrne, MD - a drug and alcohol medicine specialist in Redfern, New South Wales, Australia - comments on a statement by Vincent P. Dole, MD, the "father of MMT," that with appropriate methadone treatment opiate injecting should be eliminated in close to 95% of addicted patients. Since HIV and hepatitis are so prevalent today, this goal is still of the highest priority. Yet it often remains illusory. Why?*

Dr. Byrne writes:

Dole's original 1965 description of methadone treatment involved 22 patients who were prescribed high doses by today's standards. The average was over 100 mg with several as high as 180 mg daily, and the reported results were extraordinarily favorable by any standards.

Doses prescribed in more recent times have been less than half this level and outcomes generally less favorable. Toxicity in regular maintenance patients is almost unknown, and the drug seems to have no significant long-term side effects. However, many clinics still use arbitrary dose ceilings, often determined by administrators with no regard for the medical literature.

Dose Ceilings

Sometimes this cut-off was determined by requirements for further paperwork at certain levels. This may have suited some people with no understanding of addiction and who had an obsession with "dose minimization" in the misguided belief that this speeded "recovery."

However, it is not advisable for methadone reductions to commence until stability has been achieved and there has been a major change of focus in the patient's life. It would be unreasonable for arbitrary limits to be placed on other medications, such as insulin, cortisone, or warfarin, all of which are prescribed according to individual clinical circumstances.

It should be stressed that new patient dosing in the first two weeks is a quite separate issue. The starting methadone dose should not be more than 30 mg/day, and early increases should only be allowed in patients with demonstrated abstinence syndrome.

Blood Plasma Levels

A study by Forrest Tennant, M.D. selected a number of regular methadone patients who were all taking 80 mg daily and were considered unstable by clinic staff. All were found to have low or undetectable levels of methadone 24 hours after supervised dosing. Consistent with increasing blood levels, drug use outcomes improved substantially after a graduated dose increase to 100 mg/day.

This same study could apply to any patient who is using supplementary drugs. If the trough plasma level is low, then a dose increase may be indicated. Doctors are familiar with a similar rationale with other drug therapies such as digoxin, lithium, or phenytoin. In these cases, what might be a lethal dose in one patient may be an inadequate dose in another.

Clinical factors are still paramount in determining methadone dose. Patients who are taking low doses and who arrive early in the morning with insomnia and large pupils will usually benefit from a graduated dose increase. In principle, the methadone dose should be sufficient to take away cravings and enable the person to function normally without unacceptable side effects.

Higher Dose/Better Outcomes

Studies have consistently shown better outcomes for patients on higher doses of methadone. Most of these studies have looked at narrow ranges, but there are reports of patients taking as high as 350 mg daily before becoming stable.

Patients who request dose increases should always be given a good hearing. Research indicates that even when patients are given freedom to choose dose levels, they do not increase the average dose substantially.

Where there is any question of toxicity, or if the dose is at a level with which the prescriber is uncomfortable, there are two diagnostic approaches to consider:

1. Examination of the pupils, physical and mental state three hours after witnessed dosing can ensure that patients are not being overdosed;

2. A blood test at either peak or trough times can also be helpful.

As long as patients remain under dosed, they will feel uncomfortable for part of the day, and they may not sleep at night. They may then be tempted to use heroin, purchase illicit methadone, inject take-home doses, and/or consume sedatives or excess alcohol.

MMT practices with mean doses below 60 mg/day should look hard at their patient groups. This is still far below Dole's mean dose of 100 mg/day-plus with its enviable "success" rate.

A most fundamental job of physicians is to prescribe safe, effective doses of appropriate medications to their patients. In the case of methadone, many clinicians have been unwittingly under dosing a proportion of patients over the years.

In separate correspondence, Dr. Byrne described a study in his own medical practice. Ten methadone patients who had continued heroin use or cravings were prescribed between 150 to 350 mg/day, based on serum level evaluations. As a result, the high dose patients, possible fast metabolizers of methadone, appeared to virtually cease all heroin use.

Worrisome State Proposal (from p. 1).

great quantities of time or resources. Methadone patients and their families can make a big difference in their state by merely writing letters to their state legislators and governor—just a short letter stating that government policies concerning opiate agonist treatment (OAT) is important to you, explaining how you, a friend or family member have personally benefitted from OAT and why you think it is important that treatment be accessible in your state/community. If the state or local government is considering adopting new policies or regulations, simply write a similar letter to policymakers, including your position on the particular proposal[s]. If you would like to write such a letter to policymakers but are stuck for words, contact DON'T/***Methadone Today*** for help [see bottom of page 4 for contact information].

Dear Methadone Today (from p. 1).

Mainly, what I'd like to find out is:

1. Does the reduction from 4 mg to 2 mg (a 50% reduction) feel that much worse than when the 2mg represents just a 5 or 10% reduction? (i.e. 20 mg to 18mg)?
2. Is there some point at which a person can take a couple of weeks off from work and just go "cold turkey" without too much pain? Would that be at 10 mg? 5 mg?
3. At some point, do my dopamine or endorphin receptors in my brain become so shrunken or diminished in number that it is too late to try to quit, without being depressed the rest of my life?

Some people were born endorphin deficient, and probably need to stay on methadone indefinitely to make up for it. I am not that way–I was fine for 40 years as a casual user (usually only once or twice a month – sometimes no use at all for several years) until I "accidentally" got myself hooked. The people at my clinic try to be helpful, but they really just say "everyone is different". If I can get more information from you and your other readers, it would be very helpful. Thanks, you guys are GREAT!! **-Anna**

Dear Anna,

Thank you for writing us with your comments and questions. We are glad that you found the information about traveling to other countries helpful.

We urge our readers to help you by writing in their experiences with tapering and what their experience has been. We can offer you some general advice but probably not all the specific answers you are looking for. In this case, your clinic is right—everyone ***is*** different. As a rule, the slower the taper, the greater probability of completely withdrawing.

In response to question #1, in general, it is the percentage of decrease that matters. For example, a methadone patient on 100 mg may do perfectly fine dropping 10 mg in a month's time (a decrease of 10%), but for a patient on 20 mg, dropping 10 mg in a month (a decrease of 50%) would almost certainly be too rapid.

On the other hand, we would advise you to adjust your dosage based on how you feel rather than relying on a magic number or percentage to drop. Start tapering slowly and then continue based on your withdrawal symptoms or lack thereof, or whether you are starting to experience opiate cravings, etc. If at any point you find that you dropped your dosage too rapidly, you can ask the physician to delay the next scheduled decrease in dosage or even increase your dosage temporarily. This may seem to you like going backwards, but it is better than having a relapse or being unable to function.

Many of the patients we have heard from who have/are attempting to taper found that a rigid schedule is not the way to go. After decreasing your dose by a certain amount every other week for a period of time, you may find that you need to remain on the same dose for an extra couple weeks or so until you stabilize on your current dose before dropping again. A good physician will be willing to adjust the taper as you go.

When determining whether you are ready for another drop in dose, you should consider more than physiological withdrawal symptoms. For example, if you begin to experience depression or start thinking about using drugs, opiate or otherwise and including alcohol, even "recreationally", you may want to delay reducing your dose. You may even want to give thought to a dose increase, depending on how serious your depression and drug desires/cravings are. Methadone withdrawal should not be looked at as a race, no matter how anxious you are to get off of methadone.

Question #2, regarding taking a couple of weeks off work and going cold turkey is impossible to answer. You would certainly not want to do so at 10 mg and probably not 5 mg. With liquid methadone, you can withdraw right down to 1 mg. In fact, we have heard of patients staying on 1 mg for months. In another case, a patient was doing a "blind taper" and did not know when she had taken her last dose. We do not agree with "blind dosing" unless the patient requests it, but it is an option if the patient thinks the psychological aspect of the taper would be to his/her advantage.

In response to question #3, we cannot give you a specific timetable as to when the chemical imbalance becomes permanent. In fact, many opiate addicts may have been born with a permanent defect of this nature. In general—for whatever reason—those who were actively addicted to short-acting opiates for longer periods of time are less likely to remain abstinent once they have withdrawn from methadone. However, you do not have to be concerned that if you remain on methadone maintenance treatment for too long that you will not be able to [physiologically] function properly without opiates. If anything, the probability of withdrawal without relapsing to short-acting opiates is higher for those who have remained on methadone maintenance for a longer period of time. Thus, you do not have to worry that if you stay on methadone maintenance for X number of years that you have "blown" your chance to withdraw from it.

In past issues, we have cautioned our readers that the relapse rate is very high for those tapering off methadone. Many methadone maintenance patients—due to a permanent brain chemical imbalance—will not be able to remain abstinent of opiates or at least function normally (without depression, etc.) should they taper off of their maintenance dose.

However, in your case--given what you have told us--you may be a good candidate for attempting a taper. You have the desire to withdraw. . . seemingly for the "right" reasons. You must really want to do so—not for a family member, because your counselor is pressuring you, etc. We still advise caution and frequent consultation with your physician.

The consequences of relapse are serious: contraction of HCV or HIV if using shared needles; overdose; the risk of arrest and criminal prosecution for purchasing, possessing and using illicit opiates; etc. If, following withdrawal, a relapse seems imminent or likely, returning to methadone treatment, at least for a period of time, may be the best option.

Whatever you decide to do, we wish you well. However, before attempting to withdraw, remember—you should have your life in order, with a minimum of stressors. Stress is the most frequent reason for relapse.

ARM and Chapters

Both national Advocates for Recovery through Medicine (ARM) and the ARM Chapters, of which DON'T is a part, have been busy and productive. ARM has grown from 22 chapters at the beginning of 2001 to over 30 chapters by the end of 2001. A full listing was printed in the Winter Issue of *ARMED with Facts*. And since that issue was printed, we have added several more chapters.

In February, ARM-DC and ARM-MA attended the SAMHSA sponsored conference held in Boston learning the how-to's of grant writing

In March, ARM-MA, ARM-DC and ARM-CT attended the "Best Practices Conference" for opiod treatment programs in Newport, RI. Great lunchtime session given by Alice D'Orio, of NAMA, who boldly stood up and told the audience of more than 200 doctors, program directors, staff, and state regulators, "I am on 1100 mg (no, this is not a misprint) of methadone daily, and I am standing here to tell you about it." The advocates all applauded loudly, and many other jaws dropped in the audience. Also an excellent presentation by Lisa Mojer-Torres, a longtime advocate and Dr. Salsitz' physician prescribing patient. Also in March, ARM-MA, ARM-TN and ARM-DC attended a two-day "National Mental Health Syposium to Address Discrimination and Stigma."

In May, ARM sponsored a booth at the Lindesmith/DPF 2001 International Conference held in Albuquerque, NM. ARM-NM and ARM-DC "manned" or (wo-manned) the booth—also made visits to the three Albuquerque programs and handed out patient education materials. Great lunchtime presentation by Governor Gary Johnson of NM, who is an opponent of the War on Drugs.

And FINALLY on May 19, the new Federal MMT Regulations became "law". Several ARM chapter directors all over the country, including ARM-DC, ARM-PA, ARM-NY, ARM-CT, ARM-MA and others, attended various CSAT-sponsored regional "educational seminars" on the new Federal Regs. CSAT clarified some questions about the regs, but many topics became even more confusing. One thing was made perfectly clear at these seminars--the fact that 'CSAT does not consider "'callback' policies to be diversion control", so if you are battling with this issue at either the program or the state level, you have the Feds' backing.

Chapters continued their work during the summer. Lindesmith/DPF was kind enough to mail over 30,000 copies of their excellent "About Methadone" booklets to all ARM chapters. CSAT did a major mailing of "FAQs for Patients on the New Fed Regs" (written by ARM-DC), "Heroin Addiction and Methadone Treatment" and other educational materials for chapters to disseminate in their own area.

George Clarke of ARM-CT finished the first two ARM phamplets, "Trust" and "The Right Dose", which have also been sent to all chapters for distribution. George has been doing some great work. ARM-NC hosted a week long "Methadone Education" Series that was a great hit.

The DONT Chapter of ARM will celebrate their 7th anniversary of publishing ***Methadone Today*** in August 2002. Back issues of the newsletter can be found at http://www.methadonetoday.org

September is "Recovery Month." Several chapters had events planned in 2001, but most were cancelled due to the 9/11 disaster. ARM-DC, for example, had scheduled program visits for every weekend during September, but all were cancelled. SAMHSA sponsors "Recovery Month" every September. They have lots of free materials to give you ideas, and its not too early to start planning for this coming September.

October brought the "Voices and Faces of Recovery" conference held in St. Paul. This was the first national conference of all types of "recovery people." This was the first time MMT advocacy was included at the table. NAMA sent some delegates; ARM-MN, ARM-WI, ARM-MI (DONT), RM-NC, ARM-TN, and ARM-DC were in attendance. Some great educational materials have come out of the conference.

Back to back to this conference was AMTA. ARM sponsored a booth, together with NAMA and AFFIRM. ARM's educational materials were scooped up, including the Winter ARMED with Facts, the "Trust" and "Right Dose" brochures, and the "Heroin Addiction" booklets. ARM and the other advocacy groups were very proud to present Dr. Marc Shinderman, of CAP Quality Care, with the first "Illimination Award" for excellence in MMT. This award was created by all the MMT advocacy organizations. ARM chapter members visited all the programs in St. Louis and gave out patient educational materials. All the attendees had a great time meeting "in person", and we all learned a lot about what is going on in MMT in the US and the world.

If we left any chapters or chapter news out, we apologize. ARM has grown so fast and so large, it seems like something new is happening every month!

The CSAT sponsored "Advocacy Coalition", of which ARM is a part, had a meeting in February to discuss what we have done and where we are going. In the second year of this project, we will be publishing a DVD/Video on Office Based Methadone Treatment (OBOT). This will be an educational video directed at patients, policy makers, physicians, and the methadone programs themselves. The film will include interviews with OBOT patients and those who have not had access to MMT due to overregulation and lack of slots. There will also be an interview with Dr. Salsitz, the longest running OBOT provider in the US. The "Advocacy Coalition" will also work on publishing an educational packet directed at patients, the general public, policy makers and physicians, similar to the "Methadone Community Education Kit" which can be obtained free from NCADI--Call (800) SAY NOTO). It seems that our most important work is ahead of us. Many states are in the process of rewriting their own State Methadone Regulations. NOW IS THE TIME TO ADD YOUR INPUT. Several ARM chapters have already been successful in influencing their own state regs for the better. Every state must have a "public comment period" before they promulgate new regulations. Please, contact your own State Methadone Authority. The addresses can be found at www.atwatchdog.org or www.methadonetoday.org/state_ma.htm. Get a copy of the "draft" regulations and write your comments. If your State holds hearings, TESTIFY. Personal testimony about the miracle of methadone is very effective. This is a once in a lifetime chance to change the onerous regulations governing MMT in the US. We need to seize this opportunity.

We would like to thank everyone for your help. We would also like to encourage you to think about helping us financially by making a small donation to ARM (tax deductible, of course!). If it is time for you to renew your membership, please do so, and if you are not a member, please consider joining, and how about asking your family members to join too? What about your friends and other patients at your program? We need every bit of support we can get, even if it is stamps to help send out letters to legislators.

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DONT 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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