

# Methadone Today

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Dear Methadone Today,

I am an RN Clinician in methadone maintenance with a well-known company based in the Northeast U.S. I am also in recovery and feel as though I need to provide my clients with as much positive reinforcement as is possible. I am starting a Methadone Anonymous meeting at the clinic where I presently counsel patients on Methadone Maintenance.

I have to be honest with you and tell you that I come from a twelve-step background where abstinence was mandatory, and when I first began my position with the present company, I thought that was the case with all addictions. Since I began counseling patients at this clinic, I was afforded an opportunity to realize how insidious this particular addiction has escalated, and in trying to show my patients a better way of living, the particular problems that were related to this addiction could not be managed as other twelve-step programs are.

I was fortunate enough to have attended schools and classes on the subject, and my opinion toward methadone maintenance has definitely changed. I still feel that the only way for recovery to occur is through the twelve steps.

My reason for coming into this field is to be able to help another recovering addict get and stay clean and sober a day at a time. In counseling the clients that I do, it has become evident to me that methadone is a useful tool, and only after the client's basic needs are met can the recovery process begin. I want the best for the clients that I have come to hold very dear. They have taken my preconceived ideas about who and what a heroin addict is, opened my mind and allowed me to be able to afford the client the individuality that I afford anyone for whom I care. I would like to continue to provide to my clients the best care that I can give them. So I am requesting that you send me any information that I can use to help become part of the solution.

Anything that you can send to me will be appreciated by myself and my clients. Thank you for making *Methadone Today's* website available [see bottom of page 4 for site information].

-Len, RN, AC (Cont. p. 3)

## Introduction to Methadone Treatment

*The following is reprinted from the handbook, "About Methadone," published by The Lindesmith Center-Drug Policy Foundation. We decided to reprint portions of this handbook due to the excellent and concisely written information, as well as the positive reaction methadone treatment staff and patients have had to it.*

People usually enter methadone treatment because they feel overwhelmed by their dependence on heroin or other opioids. But not everyone who comes into methadone maintenance has the same goals. Some people want to stop taking street opioids for good. Some want to temporarily stop taking street opioids. And some want to reduce or re-regulate their use of street opioids.

Some people begin methadone with the belief that they will need medication indefinitely. Others feel that they will only need it for a short time. Regardless of what you hope to get from methadone maintenance, however, all the evidence agrees on these several points:

--People dependent on street opioids who receive methadone treatment are healthier and safer than those who do not. They live longer, spend less time in jail and in the hospital, are less often infected with HIV, and commit fewer crimes.

--Longer periods of methadone maintenance are better than shorter periods. The longer you stay on methadone maintenance, the better the overall outcome. Indefinite treatment often means life-long extension of good health, HIV seronegativity, and freedom from incarceration.

--Methadone maintenance is treatment for people who are dependent on opioid drugs. It is not a treatment for people whose major problems are with other drugs--such as cocaine, alcohol, benzodiazepines, or cigarettes.

Opioid drugs include all the drugs that come fully or partially from opium and synthetic drugs that have similar effects. Morphine, heroin, codeine, methadone, Dilaudid, LAAM, and fentanyl are opioids. (Factoid: In *Methadone Today*, we use the terms "opiates" and "opioids" often. Although we generally use these terms interchangeably, they are not identical. Opiates are drugs extracted or derived from the opium poppy. Morphine and codeine are examples of drugs that naturally exist in the opium poppy; ( p. 3)

Dear Methadone Today,



I was especially interested in this article about methadone in jails for three reasons. First, my husband does prison ministry. Second, I have often feared if ever I were to be arrested and was innocent, because I never do anything to jeopardize my freedom, but anything could happen. For instance, I could be driving my teenage daughter's car, and if she has marijuana in it and bang, a police officer finds it and arrests me. I would die if they ever tried to detox me cold turkey. I've been on methadone for over 25 years and I am on a reasonably high dose [I actually wish it was higher, but my clinic doctor has some really antiquated ideas about dosing].

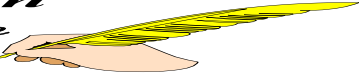
The third reason I am interested in this issue is that recently I tracked down an old friend of mine. He was one of my

friends who had also detoxed when I made my first attempt in 1976, two years after getting on the program. I had the sense after one summer of craziness to get back on the program. He did not, and when I tracked him down, he was in prison and has been there for almost the whole time that I haven't seen him. His only crime is that he is a "junkie". Pardon my using that word, but I always really liked it and thought it was cool (isn't that sick)? It really reaffirmed to me that I was truly blessed to have methadone, because without it, I would be in jail or worse. Instead, I am a home owner with a really good job.

In conclusion, I sent you a small check to help out with the cause, along with my new subscription. Your newsletters and email really mean a lot to me; they truly help keep me sane. Keep the faith and keep up all your wonderful work in advocacy.

-Vickie

## Column From the Doctor



**Dear Doctor,**

Many U.S. methadone clinics "ban" benzodiazepines (i.e., Valium, Xanax); that is, any use of benzodiazepines [which is determined by drug testing] is treated as illicit drug use--even if the patient was legitimately prescribed a benzodiazepine by a physician. Do you agree with this policy? Also, is the prescription of benzodiazepines ever justified in methadone patients? **-Wayne**

**Dear Wayne,**

The issue of benzodiazepines is almost the same as alcohol. Sometimes such use could be classified as "discretionary" or even "recreational" but on other occasions it is very clearly "therapeutic", such as for epilepsy or panic attack treatments. I know some patients who say a certain amount of alcohol is, for them, therapeutic, and nobody would consider a "couple of drinks" after a day's work necessarily dangerous.

Benzodiazepines have a great deal in common with alcohol, and we should never reject a patient from methadone treatment for drinking excessively or for taking tranquilizers. However, such behaviour (sic) should flag the need for close assessments and added services to be offered, knowing of the increased risks involved. The very issue of a patient having two doctors should not arise since before putting a patient onto methadone, a good specialist clinic would normally seek a referral from the patient's usual doctor and send a report of progress so treatment is coordinated. Unfortunately, owing to the nature of some clinics, this does not always happen and patients' treatment can become a confusing "hodge-podge" of arbitrary and ill-conceived decisions.

It is simply illogical to base important decisions relating to opiate addiction treatment on the patient's use of benzos or alcohol. They are in treatment by definition for opiate dependency, and other intercurrent problems need to be treated individually and sensitively. Cannabis [marijuana] is the most obvious, where apart from simply education on the dangers, such as with fatty foods, there is little point in any medical intervention in most cases for patients on methadone maintenance treatment.

My feeling is that all people are better off without benzodiazepines if they can cope with reductions. Most can reduce to zero as long as they are receiving adequate doses of methadone, which abolish cravings for 24 hours. For a small proportion, perhaps 10%, repeated attempts at reductions have resulted either in relapse to uncontrolled drug and alcohol use or the occurrence of unacceptable anxiety/panic symptoms. These patients should be given access to small doses of supervised diazepam in most cases, which should be given along with their methadone, with dispensed doses for take-home days. Some patients can regain control of their tranquilizer use, but others will need continuing supervision up to three times weekly.

**Dr. Andrew Byrne**  
**General Practitioner, Drug and Alcohol**  
**New South Wales, Australia**

**Editor's Note:** We respect Dr. Byrne's belief that ideally treatment should be coordinated. However, such coordination rarely exists in the U.S. between substance abuse treatment and other medical treatments. In the case of treatment of certain mental illnesses, some methadone clinics (either the physician who makes dosage/treatment decisions or an in-house psychiatrist) will actually provide such treatment--including the prescription of medications (i.e., anti-depressants for clinical depression or benzodiazepines for anxiety). But the majority of methadone clinics do not have in-house psychiatrists and will not provide treatment for mental illness beyond the "counseling" provided to patients. Although these clinic counselors may be able to help with some psychiatric problems, many methadone clinic counselors are not psychologists or psychiatrists and are, therefore, not qualified to treat mental illnesses. . . and, of course, cannot prescribe medications.

In our experience, many methadone clinic physicians have no interest whatsoever in providing treatment for mental illness or anything else aside from drug addiction. These physicians may refer patients to outside doctors but will not take any kind of role in such treatment. At many clinics, patients cannot even see a doctor unless they have a specific issue directly related to drug addiction/methadone treatment. We bring this up, not as a criticism of clinic physicians, but to point out the way it is. We do not necessarily expect methadone clinics to provide treatment for mental illnesses and other medical conditions, but if they are not going to provide such treatment, they ought to respect medical treatments provided to patients by outside doctors. Thus, a universal ban on certain medications by methadone clinics is unreasonable. If an outside doctor prescribes a medication, the clinic should accept that it is medically necessary.

Another interesting issue Dr. Byrne raises is how methadone clinics should handle certain non-medical drug use--at least in cases where the patient is not addicted to the drugs being used. Many methadone clinics do not concern themselves with alcohol use if there is no evidence that the patient is addicted to alcohol, as long as s/he is not actually under the influence of alcohol when attending the clinic. In part, this is for practical reasons--breath and blood tests generally only detect alcohol while the individual is under the influence. Clinic staff may also be unwilling to address moderate alcohol use, since alcohol is a legal drug. Except in a handful of states, treatment providers are not required to test for marijuana. Still, many methadone clinics do regularly test for it. We question whether they should be testing for marijuana, at least in cases where there is no evidence of marijuana addiction. Methadone clinics have been known to basically drive patients out of treatment for marijuana use. We cannot agree with such tactics when the consequences of cessation of methadone maintenance treatment are far worse than any possible harm resulting from marijuana use.

One final observation is that the patient should seek a second and maybe even a third opinion on the best course of treatment for a panic or other anxiety disorder--or any other mental illness--where benzodiazepines are being prescribed. Given that treatment is often improperly coordinated, multiple medical opinions are important in order to get proper medical treatment.

We would like to say that all physicians are well-informed regarding methadone maintenance treatment and potential drug interactions, but this is not the case. As Dr. Byrne states above, increasing the dose of methadone may eliminate the need for benzodiazepines or at least reduce the required dose of benzos.

Methadone increases the effects of benzos, and benzos increase the effects of methadone. Therefore, dose determinations can be quite complex. For example, a methadone patient who stops taking benzodiazepines will need a methadone dose increase just to prevent the onset of opiate withdrawal symptoms.

**Dear Len (from p. 1).**

We hope the links we sent you were helpful. We appreciate the fact that you have changed your mind about methadone maintenance treatment. The Institutes of Medicine, National Institute on Drug Abuse, the American Medical Association, and others state that methadone maintenance is the most effective treatment for opiate addiction.

Opiate addicts have a deranged brain chemistry. Once methadone is withdrawn, the patient returns to daily short-acting opiates (i.e., heroin, Percodan) within a short time in 80-90% of the cases.

Such high relapse rates are not the result of a lack of desire to remain abstinent, a shortage of "will power", or because the patients are moral degenerates. Rather, opiate addicts have a physiological problem, which methadone maintenance treatment corrects. This explains why many patients manage to abstain from short-acting opiates and function normally for long periods of time while on maintenance treatment, yet relapse shortly after tapering off of their maintenance dose.

We respect your opinion regarding twelve step programs but do not agree that twelve step programs are always necessary to successfully treat addiction. There is a difference between saying that many drug addicts have succeeded with the help of twelve step programs and saying that twelve step programs are always necessary or even the best means of treating drug addiction. There are other treatments which have philosophies quite different from twelve step.

We understand that many nurses and counselors share your opinion that attending twelve step meetings is necessary for recovery. But many people succeed in overcoming drug addiction without attending twelve step meetings, reading twelve step literature, or adhering to twelve step philosophy.

In fact, there are other recovery organizations with philosophies quite different from twelve step, though they do not have as many members as twelve step organizations such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). One organization that comes to mind is Rational Recovery--whose philosophy is virtually opposite that of twelve step organizations.

The point is that twelve step is not for everybody. Twelve step philosophy heavily intersects with religion, and there are people who do not share the Western religious outlook upon which it is based. In particular, some atheists resent the twelve step belief that recovery from drug addiction requires belief in a "higher power."

Whether it is a misinterpretation of twelve step philosophy or not, twelve step literature has sent the message that recovery is not possible for atheists--unless they will change their religious/spiritual beliefs. Others may only need the medication or simply do not feel comfortable speaking in a group (whether a twelve step meeting or other group therapy). Rightly or wrongly, some people feel that twelve step groups are too judgmental. These statements are not intended to serve as a condemnation of twelve step programs; to expect that one type of program to be mandatory or appropriate for everyone is unreasonable.

In any case, a challenge for twelve step groups is to accept that drug addiction --at least in some cases--is the result of a physiological imbalance, which may be corrected by medication (i.e., methadone). In their literature, NA explicitly rejects methadone maintenance treatment. Not only do they reject it as a legitimate drug addiction treatment, they regard the use of methadone, when legitimately prescribed and used as prescribed for the treatment of opiate addiction, as equivalent to active drug addiction (i.e., addictive use of heroin or other drugs). Alcoholics Anonymous does not have such a policy, but that doesn't necessarily mean that they accept methadone maintenance treatment as a legitimate drug treatment (they do not take a position on prescribed drug use).

In some cases, twelve step groups accept methadone maintenance grudgingly. They still believe that being abstinent from all opioids is "better" than taking methadone--but they accept methadone maintenance in some cases, because they realize that some opiate addicts could not remain abstinent from short-acting opiates if they were not in maintenance treatment.

We do not agree with this sentiment. Methadone maintenance is a medical treatment, and therefore, in the context of maintenance treatment, methadone should be viewed as a medication. Taking a medication does not make one less successful in recovery or in any other area than those not taking medication.

We hope that the twelve step community will change their mind about the use of medications such as methadone, as you have. Twelve step organizations would be making a real mistake by going down the "slippery slope" of deciding what medications are acceptable--especially in the treatment of drug addiction. Instead, they should be embracing new drug addiction treatments.

Good luck with the Methadone Anonymous meetings. We are always happy to see groups that methadone patients may attend without having to either conceal the fact that they are in methadone treatment or be negatively judged for taking this life-saving medication

**Introduction (from p. 1).**

heroin (diacetylmorphine) is an opiate, since morphine or codeine, which the opium poppy contains, can be converted to heroin. For a definition of opioids, read the last paragraph above. All opiates are opioids; however, some opioids are not opiates. Synthetic drugs that are not manufactured/derived from the opium poppy, but which have effects similar to opium derivatives, are not classified as opiates, but are opioids. Methadone and fentanyl are examples of synthetic opioids that are not opiates.

**Dear Vickie (from p. 1).**

Dear Vickie,

Thank you for sending this letter and your donation/subscription]. We are always interested in hearing from readers and their thoughts on the articles we print. We try to cover a variety of issues, even if every issue does not interest every reader. Although most of us probably do not expect to wind up in jail or prison in the near future, we nonetheless feel that this is an important issue.

In fact, you make an excellent point--that there are inmates who are in prison or jail simply for being a drug addict. An individual may not be incarcerated for being addicted to illicit drugs, but active addiction entails the purchase, possession, and use of illicit drugs--all illegal activities.

Even if society is not concerned with the welfare of drug addicted inmates, we nonetheless feel that this is an important issue. In fact, you make an excellent point --that there are inmates who are in prison or jail simply for being a drug addict. An individual may not be incarcerated for being addicted to illicit drugs, but active addiction entails the purchase, possession, and use of illicit drugs--all illegal activities.

Even if society is not concerned with the welfare of drug addicted inmates, this issues affects them. Most inmates will eventually return to society. Opiate addicts in methadone treatment commit far fewer crimes. If opiate addicts are not dosed in jail, they will be far more likely to return to prison or jail--at substantial expense to taxpayers.

## Guide to Medications Used in Opiate Addiction Treatment (part 2)

The following is the second of a two part guide to medications used in opiate addiction treatment. This guide contains general information about the treatments, who they are used for, and their basic regulatory status. This guide should not be used as a final basis to self-diagnose or decide upon the best treatment in a particular case. Speak to a doctor about what treatment is best for you.

### Medication: Naltrexone

**Who:** Opiate addicts who are NOT presently opiate dependent (will trigger severe withdrawal in opiate dependent patients). Naltrexone is often used in opiate addicts who have already detoxed or who are actively addicted, but not to the point of physical dependence. Used in such circumstances, naltrexone is meant to block the effects of opiates [should the patient relapse] and reduce narcotic cravings (under the theory that the patient knows that using opiates will not generate the desired effects). Naltrexone is also used in the so-called UROD (rapid detox) treatment--but for a different purpose--to intentionally trigger withdrawal and supposedly, to decrease the duration of serious withdrawal symptoms. \*For purposes of this chart, we will not discuss the use of naltrexone in UROD, as we have already covered UROD in past issues. Note that we have corresponded with many individuals who had a very bad experience with UROD.

**Regulatory status:** Naltrexone can be prescribed by any physician--no specific rules or regulations exist. Because naltrexone does not cause intoxication and patients cannot become physically dependent on it, regulators and treatment providers are not concerned about take-home supplies [and diversion of]. However, treatment providers often prefer the medication be taken under supervision of a family member (out of fear that the patient will stop taking the medication for various reasons). For this reason, some physicians prefer to use naltrexone implants (a surgically inserted device that releases a steady stream of medication for a certain period [months]); however, some experts have questioned the use of these implants, since they have not been thoroughly tested. A malfunctioning implant that is not releasing the amount of naltrexone it's supposed to could result in the patient overdosing on opiates [should the patient use opiates].

**Comments:** While naltrexone may be a good medication for patients who don't want/need maintenance, many individuals have told us that it does not do much to suppress cravings. It also does nothing to correct the underlying chemical imbalance many opiate addicts are believed to suffer from; in fact, it is quite possible naltrexone makes the problem worse, since it presumably blocks the natural endorphins (an opiate-like substance that is important for normal function--many believe that it is the under-production of natural endorphins that is at the source of the aforementioned chemical imbalance).

### Medication: Ibogaine

**Who:** Opiate addicts. Ibogaine is a derivative of a hallucinogenic plant, and is used to detox off of opiates, as well as some other drugs. Preliminary research has been promising.

**Regulatory Status:** Ibogaine is not approved for the treatment of opiate addiction or for any other purpose, and is illegal. Approval is unlikely in the foreseeable future, and obtaining treatment on a research basis has not been possible--litigation resulting from a patent dispute has apparently put the brakes on Ibogaine research. Individuals with the time, motivation and finances, may be able to obtain treatment with Ibogaine in another country.

**Comments:** One apparent advantage of Ibogaine is that it only has to be taken once [per detox] and physical dependency on Ibogaine is impossible. Not enough research is currently available to draw definitive conclusions about safety (especially for those with liver problems, HCV, or cardiac conditions); but it does appear to be pretty safe, particularly if the treatment is provided by someone with knowledge and experience with Ibogaine and its effects. Ibogaine does have strong hallucinogenic properties, making it undesirable or unsuitable in some individuals (especially those suffering from certain mental illnesses). Not enough is known about the interactions between Ibogaine and various [non-opioid] prescription drugs, so individuals on multiple prescribed medications may be better to avoid this treatment for now.

**Medication:** Clonidine, Valium, etc. In this category, we are including a variety of non-opioid medications used to ease withdrawal symptoms during a detox (in lieu of using opioids to taper/detox).

**Who:** Treatment with these medications are for opiate addicts who are currently physically dependent on opiates.

**Regulatory Status:** These drugs are approved for the treatment of opiate addiction and any physician may prescribe these medications without being an OTP. Few rules exist for take-home supplies, etc., but some of these drugs can cause physical dependence and are somewhat harmful if used for long periods of time, so physicians are reluctant to prescribe for more than a very short period.

**Comments:** If too high of a dose of clonidine is taken, dangerously low blood pressure may occur (it is actually used as a blood pressure medication). Use of Benzodiazepines can result in addiction and physical dependence, so care must be exercised when using these drugs to help detox off of opiates. Generally, these medications only ease withdrawal symptoms satisfactorily in individuals with a relatively low level of opiate dependence. As with most detox treatments, these medications only help relieve physical symptoms during withdrawal, they are not a cure for opiate addiction, nor do they help prevent a relapse once the patient has finished withdrawing from opiates.

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