

Methadone Today

The official newsletter of DONT—by patients, for patients August 2003 Volume VIII Number VI

Methadone Ban for Truck Drivers-- Rule Needs to Be Changed

Methadone maintained patients considering a career as a truck driver or current truck drivers suffering from opiate addiction and who are contemplating methadone treatment receive an unpleasant surprise when they attempt to obtain or renew a DOT license to drive a truck. In order to drive a commercial truck, drivers need more than a standard drivers license--and commercial truck drivers are subject to far more extensive regulations than drivers of automobiles. Nowhere in the United States does being in methadone treatment disqualify an individual from obtaining a drivers license and operating an automobile.

The DOT regulations indicate that the use of legitimately prescribed medications by truck drivers is permitted. Truck drivers may drive while on such prescribed medications, "if the substance or drug is prescribed by a licensed medical practitioner who is familiar with the driver's medical history and assigned duties and has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a commercial motor vehicle." These regulations do not ban or place any additional restrictions on specific medications--with one exception: methadone.

A review of the DOT's ban on methadone is well overdue. All the research that has been conducted regarding methadone maintenance and ability to drive indicates that stabilized methadone maintenance patients are not impaired by their medication and are as fit to drive as the general population. Anecdotally, automobile accidents blamed on methadone are virtually unheard of (*this statement refers only to methadone being used by methadone patients--not illicit use of diverted methadone, and excludes cases where the methadone patient was also under-the-influence of illicit/non-prescribed drugs). The fact that no states have adopted regulations banning or restricting the operation of automobiles by methadone patients is indicative that methadone maintained patients have not caused a disproportionate number of accidents. It is also telling that the DOT regulations were never amended to extend the ban on methadone to LAAM (another opioid **(Cont p. 3)**)

Methadone--My Lifesaver

by Debra

Methadone literally saved my life and saved my 3 children from being motherless. I started out using Percocet and Vicodin due to (at first) many gyn problems that were very painful, then I started dabbling in morphine and Fentanyl and then eventually, my worst mistake, Oxycontin. My "addiction" to opiates lasted roughly four years. In the beginning, I could take one-half of a 40 mg Oxycontin and be "all set" for the day. Toward the end, I would have to chew two or three 80 mg Oxycontin. . . and that wouldn't last the whole day. In order for me to stay high for an entire day, I would have to take that amount three times per day--morning, afternoon, and early evening.

I would cry all day because I didn't know what I was going to do or how I was going to get myself out of this mess. I had no idea there were detox centers for Oxycontin—I thought they were only for heroin. I knew nothing of methadone for Oxycontin, and knew little about methadone for heroin. I ended up finding a detox center that used methadone and from there was put on methadone maintenance at a clinic in my hometown.

I can honestly tell you that methadone saved my life! When I was active, I would sit and plot how I was going to end my life because I saw no other way out of this mess I had gotten myself into. I have been on the methadone clinic for about six weeks now and have NEVER once "used." I know it's the methadone that is saving me because there was a six-day time period between the time I left the detox center and when I would receive my first dose of methadone at the clinic. I used every single day during that time period. I left the detox center and within two hours of being home, I was chewing an 80 mg Oxycontin. The reason for that was the detox center weans you off the methadone so that by the time it is like your last or second-to-last day there, you feel like crap because you are down to receiving 5 mg or 0 mg for the day. I feel that if you are transferring from a methadone using detox center and going onto methadone maintenance, they should keep your dose up and give you take homes or something to get you through the week it takes to get on the methadone clinic. But either way, I made it through that week; not a very good way of doing it but I did, and like I said, I have been on the methadone clinic for about six weeks now. **(Cont. p. 3)**

Dear Methadone Today,

I was on methadone maintenance for (1983-2001). I was a total mess getting on maintenance, and I truly believe if I would have stayed on the streets shooting junk instead of finding a good clinic with a good staff and physician, I would have died (O.D., H.I.V.) in the early years of the "decade of the excesses", the EIGHTIES. Instead I found a way to manage my opiate cravings using methadone, finish my college education, find a good job, get married, raise four wonderful children (all drug free college students), and carry on with my life.

I am no longer on methadone. Not by choice, but because we built a new barrier-free home in the Mid-Michigan area (my wife has multiple sclerosis and is now totally disabled), and there are no clinics within a 300-mile round trip. I'm 54, and it is just too logistically difficult to carry-on.

But I'm now on a comfortable level of Suboxone, which is



18 years
before

prescribed by an addiction-specializing psychiatrist from his office. I would much rather be on methadone, but the clinic closed in 1991 when its director physician retired. I thank God for methadone maintenance facilities and people who showed understanding and had empathy for our common situation. **-John**

Dear John,

Congratulations on your success in treatment. Politicians and the general public need to hear success stories, where opiate addicts were able to regain functionality, get an education, raise healthy, well-adjusted children, etc., with the help of opiate agonist treatment (methadone, LAAM or buprenorphine maintenance treatment).

It is a shame that due to government regulations, methadone treatment is still not available in many areas, such as central and Northern Michigan. Unfortunately, Michigan has outdated state regulations, which do not permit "extended" **(Cont. p. 3)**

Detox (from p. 4).

withdraw from, the majority of methadone patients wouldn't have needed opiate agonist treatment (e.g., methadone treatment) to begin with--they would have just quit heroin "cold turkey" or by gradually tapering off of it, and that would be it. Treatment providers need to do a better job of educating patients about opiate addiction and opiate agonist treatment. The difficulty opiate addicts have withdrawing from opiate agonist medications (methadone, LAAM, buprenorphine) is simply due to the nature of opiate addiction.

Actually, remaining opiate-free after withdrawing from the medication is often the biggest problem for patients, not the actual process of tapering off of the medication. In fact, a gradual methadone taper is generally the best method of achieving opioid abstinence (e.g., remaining free of opiates, without maintaining on an opiate agonist medication, like methadone or buprenorphine), in terms of relapse rates--it appears that a gradual buprenorphine taper is as good, but NOT superior to a methadone taper, in this regard.

Even though a gradual methadone taper is the "best" method known of achieving opioid abstinence, it is still associated with a high relapse rate. Approximately 80% of opiate addicts who taper off of methadone will eventually relapse. This is simply the nature of opiate addiction, which many experts believe is caused by a physiological imbalance. Methadone maintenance treatment and opiate agonist treatment with other medications (i.e., buprenorphine or LAAM) are effective treatments for opiate addiction, but are not a "cure"--that is, they work as long as patients remain on the treatment. Thus, methadone patients should think carefully before withdrawing from their medication, and should not view switching to buprenorphine as an easy way to withdraw from opiate agonist treatment.

Editor's Note: Results from a recent research study [see below, "Buprenorphine taper no simple way off methadone"] where low dose methadone patients were switched to buprenorphine, and then tapered off of buprenorphine, indicate that methadone patients interested in withdrawing from all opioids would NOT be better off switching to buprenorphine and then completely tapering off of buprenorphine. Keep in mind that the subjects in this study were "low dose" methadone patients--presumably, the outcomes would have been worse for methadone patients on higher doses (over 50 mg/day), that would have had to taper down to a lower methadone dose before even being able to switch to buprenorphine. Thus, "higher dose" methadone patients may wisely decide to avoid such a buprenorphine withdrawal method.

**Buprenorphine taper
no simple way off methadone
by Dr. Andrew Byrne, General Practitioner
(New South Wales, Australia)**

**Cessation of methadone maintenance treatment using buprenorphine: transfer from methadone to buprenorphine and subsequent buprenorphine reductions. Breen CL, Harris SJ, Lintzeris N, Mattick RP, Hawken L, Bell J, Ritter AJ, Lenné M, Mendoza E. Drug Alc Dependence (2003) 71(1)49-55.*

The findings in this paper persuade against the use of transfer from stable methadone to buprenorphine as a strategy towards successful reductions to abstinence, although the authors themselves do not state this specifically in their own conclusion.

For some reason these authors did not choose to compare a new treatment (buprenorphine reductions) with an existing treatment (methadone reductions). They instead looked at three slightly different methods of attempted transfer from stable, low-

dose methadone maintenance and showed that for many and even perhaps most it was associated with relapse.

When buprenorphine treatment was mooted in the 1990s, it came with a hope expressed by some that it may be a maintenance treatment which was easier to successfully withdraw from, despite no existing research evidence to that effect.

I believe that it is inevitable one must conclude that the specific protocols were each shown to be highly unsatisfactory and that transfer to buprenorphine and subsequent gradual reductions for up to 16 weeks should not normally be advised for low-dose (30-50mg daily), stable methadone patients.

By my reading, of the 55 subjects, chosen specifically for their stability and low dose, that by one month after the last dose, 15% were lost to follow up, 13% were using street heroin and not in any treatment, 9% were on naltrexone (an unvalidated and often unstable treatment for heroin users), 25% had been put back onto methadone for illicit drug use, 7% were not able to transfer from methadone to buprenorphine in the first place and 31% reported still being opiate free (heroin or methadone).

Thus, a relatively stable group on standard, 'safe' therapy, when offered a prospect of successful reductions, was rendered into a fragmented group, over half of whose members had used illicit heroin during the study period. Thus the 'cost' of achieving drug-free status at one month in this quite large minority was rather high for the rest. Some of those 'lost to follow-up' may have died from overdose or other causes (we are not told if coroner's records were sought). In a country with high rates of HIV and no access to clean syringes, a trial such as this would probably be unethical in my view. With these outcomes, it should certainly never be repeated.

Editor's Note: Readers should understand that such relapse or failure rates will vary over time. The failure rates in this study are high, considering that only one month had passed since patients completed the buprenorphine taper. If the subjects were tracked six months or one year after completion of the buprenorphine taper, the rate of subjects who relapsed at some point since withdrawing from buprenorphine would be higher. Thus, the outcome of this withdrawal regimen appears to be similar to, or maybe even a little worse than using a gradual methadone taper (where after one year, about 80% of patients will relapse).

**Methadone Today would like to thank our
Medical Advisory Board for their participation.**

Our Medical Advisory Board includes:

Dr. Vincent Dole, Rockefeller University;

Dr. Marc Shinderman, Owner of

Center for Addictive Problems in Chicago;

Dr. Andrew Byrne from New South Wales,

Australia, who has written two books

about methadone and addiction;

Dr. Brian McCarroll, Medical Director/Owner of

Bio-Med in Clinton Township, MI;

Dr. Charles Schuster, Director of the University

Psychiatric Center in Detroit, MI and former head

of NIDA; and his associate

Dr. John Hopper, Medical Director of UPC.

Methadone Ban (from p. 1).

medication that is prescribed for the treatment of opiate addiction--the reason for this discrepancy probably has more to do with the stigma surrounding methadone, than anything else, since there is no rational basis for it (though, the lack of an affordable drug test for LAAM may also be a factor). If there is any doubt that the DOT's ban on methadone is discrimination and is not justified by any legitimate reason, one only needs to consider all the prescription medications that the DOT has not specifically banned. There are a large number of prescription medications with a far higher likelihood of side effects that would make operating a truck dangerous, even when taken as prescribed for a legitimate medical condition. There is

What is your clinic's emergency plan for patient dosing if they are unable to open due to a snowstorm or other emergency? Find out, send it to us so we can publish it. All patients should know where to go to dose BEFORE there is an emergency.

simply no legitimate explanation for banning methadone, but not other medications, like sedatives or stimulants.

The responsible solution to the issue of prescription medications and operating a motor vehicle, is to do what the DOT has done for all prescription medications except methadone--allow medical practitioners to determine in each individual case, whether or not the prescription medication will "adversely affect" the patient's ability to safely drive a commercial motor vehicle, and advise the patient accordingly. If the medical practitioner indicates that the medication will not interfere with the patient's ability to drive safely, the individual should be permitted to drive a commercial motor vehicle.

In fact, a stabilized methadone maintenance patient experiences virtually no analgesia or intoxication from the medication, so this will not be an issue in most cases. And if the DOT examined the research, they would know that. The DOT policy concerning other prescription medications has apparently been effective at keeping

impaired drivers off the road, so methadone should be treated in the same manner--ending the discriminatory double standard placed on methadone patients.

My Lifesaver (from p. 1).

I was tested the other day. I was at a home using the rest room, and there on the counter was a big bottle of Vicodin. No one could see me, and there were lots of people at the house, so I could have gotten away with stealing some or all of the pills, but I didn't touch one! I used the rest room and went on my way.

I do not feel high from methadone, I feel "normal", like the way I used to before I developed my addiction problem. I love it and would defend it to my dying day--it SAVED my life! And stopped my three children that I am raising alone, mind you, from being motherless and subsequently becoming wards of the state, because they have no other family that would take care of them.

If you take your methadone dose the way you're supposed to, talk with your counselor, go to your group meetings, stay clean and let the methadone do what it's meant to do, it WILL work for you! Methadone literally saved my life and continues to save my life every day.

Don't forget to order your personalized, laminated Medic Alert card (see p. 4). Avoid being thrown into immediate, severe withdrawal if you are unconscious and unable to tell doctors and/or hospital staff that you should absolutely NOT receive opiate antagonists (i.e., Narcan).

Editor's Note: Debra is a good example of the "invisible" methadone patient. A highly functioning individual that does not fit the false negative stereotypes of methadone patients. Besides being a mother of three, she is a Medical Assistant, who graduated from school (that is, a technical school that educates/trains Medical Assistants) with a 3.975 GPA and was hired by the school to

work after hours to tutor fellow students. She is an intelligent, responsible, independent woman and mother. Methadone patients are no different than anyone else, except they need a medication for a medical condition (opiate addiction).

Dear John (from p. 1).

take-homes (13-30 day supplies)--which are allowed under the federal regulations. Otherwise, given your stability and time in treatment, you would have only had to make a very long commute to a Detroit area methadone treatment provider once a month. You still may not have been able to make such a monthly commute, but it would be nice to at least have that option. We are hopeful that Michigan will update their regulations--especially the take-home rules. To avoid a lengthy car or bus ride, a few methadone patients even fly to their distant methadone treatment provider once a month. Which leads me to about the only feasible option for someone like you (who lives too far away from a methadone clinic to commute there weekly, and lives in a state where extended take-homes are not permitted) to continue methadone treatment--commute once a month to another state that does permit 30-day take-homes.

In light of the continued problems with methadone treatment accessibility, it is good news that buprenorphine is now available. At this point, buprenorphine treatment providers can at least be found in some areas where methadone treatment is unavailable--including in the handful of states that still do not permit methadone treatment or that do not allow long term maintenance treatment (i.e., Ohio only permits short-term methadone treatment, and opiate addicts must commute to Michigan or some other neighboring state to obtain maintenance treatment).

Thank you for writing in and we hope that after a period of adjustment, buprenorphine treatment will work out well for you. Hopefully methadone treatment will eventually come to central and northern Michigan, and other areas of the U.S. where methadone treatment is currently unavailable, so that methadone patients will be able to continue treatment when they move to a rural area.

Editor's Note: Still, the availability of buprenorphine in areas where there are no methadone treatment providers or where there are long waiting lists to get into area methadone treatment programs only helps a portion of opiate addicts who require opiate agonist treatment.

Detox--Should methadone patients switch to buprenorphine to withdraw from opioids?

Ever since buprenorphine was approved for the treatment of opiate addiction by the FDA, we've been hearing about methadone patients withdrawing (AKA: "detoxing") from their medication by tapering down to a low dose of methadone (usually 30 mg/day) and then switching to buprenorphine--and finally, tapering off of buprenorphine until completely withdrawn from opioid medications.

We have not had the opportunity to ask many of these patients why they chose this withdrawal regimen. With some of these patients, the primary reason for switching to buprenorphine may be to escape the stricter rules and regulations attached to methadone treatment. Some patients may be moving to an area where methadone treatment is not available and figure that while they are already going through the hassle of switching from methadone to buprenorphine, they might as well take the opportunity to taper off of opioids completely.

However, it is likely that in many cases, the primary reason the patient chooses this withdrawal regimen is out of a belief that it will be easier and cause less discomfort than a traditional taper (e.g., tapering completely off of methadone, without switching to buprenorphine or some other opioid). The media and some physicians have suggested that buprenorphine is easier to withdraw from than methadone, so these patients apparently figured that switching to buprenorphine to finish their withdrawal from opioids would make it easier for them.

The first problem with this is that it has not been established that buprenorphine is easier to withdraw from than methadone. The research so far indicates that opiate addicts using buprenorphine to withdraw from opioids (using buprenorphine for "detox" purposes rather than maintenance), are just as likely to relapse as opiate addicts using methadone to withdraw from opioids. It is possible the subsequent research studies will yield a different conclusion, but as it stands now, there is no reason to believe that opiate addicts withdrawing from buprenorphine have a higher probability of success than opiate addicts withdrawing from methadone. No doubt, some of these patients would not have switched to buprenorphine had they known that there is no research supporting the theory that buprenorphine is easier to withdraw from than methadone.

The second problem with this withdrawal regimen is that switching from methadone to buprenorphine can be problematic. Some methadone patients have a harder time

switching to buprenorphine than others. As noted above, methadone patients must taper down to 30 mg/d before switching to buprenorphine, otherwise, the buprenorphine may actually trigger withdrawal symptoms. Even if it were true that buprenorphine patients had an easier time tapering off the medication without relapsing than methadone patients tapering off of methadone, it would not necessarily follow that opiate addicts already on methadone would have an easier time switching to buprenorphine and tapering off of it, than simply tapering completely off of methadone.

Ultimately, the mistaken view of many opiate addicts and methadone patients that buprenorphine is far superior to methadone for withdrawing from opioids is based on a misunderstanding of methadone treatment and opiate addiction. Methadone is often seen as the culprit: if an opiate addict tapers off of methadone and subsequently relapses, it is [falsely assumed that this is] because methadone "is hard to get off of". Of course, if short acting opiates, like heroin, were any easier to **(Cont. p. 2)**

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Methadone Today (Vol. VIII, No. VI)

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