

Methadone Today

The official newsletter of DONT--BY PATIENTS, FOR PATIENTS June 2004 Volume IX Number IV

MMT--Enlighten Public About Effective Treatment - by Dennis D.

I would like to commend your organization (DON'T) for attempting to enlighten both the treatment community and the general public regarding the truth about MMT by taking a proactive role in dispelling the myths, ignorance, and stigma associated with the most effective treatment modality available for opiate addiction.

I have suffered from and struggled with opiate addiction for over 20 years. During this time, I have gone through the gamut of traditional abstinence-oriented treatment programs, group and individual therapy, and 12-Step fellowships in an attempt to stop using opiates and have failed each time. This treatment failure was not from a lack of wanting to stop nor from not "working the program." I desperately wanted to stop but simply couldn't despite the threat of severe consequences if I resumed active addiction. The reason was simple: I could not live a single day where I was not besieged with constant dysphoria and depression despite over three years of continuous abstinence from all mood-altering substances. These manifestations could not be relieved to any noticeable extent no matter what Step I worked, how many meetings I attended, what antidepressant I was on, or how often I confided in my sponsor and therapists. There was only one thing that would end this torment. My body was screaming for the substance that would return it to stability. I eventually gave up. It had the better of me.

After much research of the literature and talking with fellow narcotic addicts, I am convinced that opiate addiction is a psychological manifestation of a physiological abnormality. There is only one form of treatment that addresses this: Methadone maintenance. It has been proven that psychotherapy alone as a treatment for depression is almost universally unsuccessful. Only when appropriate pharmacological intervention is introduced does significant progress ensue. This also appears to be true for narcotic addiction.

After having attempted abstinence-only treatment numerous times only to eventually relapse, I enrolled in a MMT program for the first time. What a long, drawn-out process this is! I applied over a month ago and finally have a meeting (**Cont p. 3**)

Dear Methadone Today,

I am 56 years old and have been on methadone since it was put into a controlled substances act. In the last ten years, I tried to get off methadone two times, each time taking at least 1 ½ to 2 years to reduce the dose--as slow AS 2 mg. a week! Each time when I got down to 8 or 10 mg., I would start to have problems! Why? My wife had a 12-year heroin history; she withdrew 2 mg. a week, and now she is CLEAN. We are on a course of divorce. She must see that I can't reach her "level" of detox! We've been married for 25 years.

HOW COME I NEED THIS METHADONE TO HELP ME IN MY DAILY LIFE? God knows that I TRIED! Damn those opiates! They have ruined my life and family--I can't tell you how many times that I've wanted to DIE! God Bless all those who suffer. -Ray

Dear Ray,

Your wife is the exception rather than the rule. Opioid addiction has been proven to be a brain chemistry problem, and most

Faith-Based Treatment - President's Speech

President George W. Bush recently spoke at a "faith-based" drug treatment facility, espousing his uninformed views on how to overcome addiction. Most **Methadone Today** readers are probably aware that President Bush was [by his own admission] an alcoholic, who subsequently quit drinking and became an Evangelical Christian (Evangelicals consider themselves "born again")--a sect that includes many of the television preachers. He credits his religious transformation for his recovery from alcoholism.

In this speech, he concluded that addicts need to, "change what's in their hearts," because, "when we change what's in our hearts, we [also] change our behavior." President Bush is certainly entitled to express his opinions, but we hope that in the future he refrains from expressing his views on drug addiction and treatment, a topic which he is clearly totally ignorant of, despite being a recovering alcoholic himself. This is a perfect illustration that simply being a former/recovering drug addict does not make one better informed or more qualified to counsel patients or speak about drug treatment. What President Bush suggests in this speech is completely contrary to modern medical understanding of drug addiction. A long time ago, the medical community determined that drug addiction is a disease--not a lifestyle choice or manifestation of a moral or "spiritual" deficiency.

In this speech and in his administration's policies, President Bush bows the official line of so-called "faith-based" treatment providers. The gist of it is that drug addicts are morally deficient and can be cured by a good dose of religious values and faith in the almighty. Again, these folks are entitled to their opinion, but their "programs" for drug addicts cannot be called "drug treatment". The real travesty is that President Bush continues to give special treatment, in the provision of government funds for drug treatment, to programs that rely primarily or exclusively on religion to help drug addicts overcome their addictions.

President Bush's "Faith-Based Initiative" not only gives special preference to such programs, it allows providers with a "faith-based" agenda to get federal funding without following many of the rules other providers are subject to. For example, staff that counsel (**Cont. p. 3**)

people WILL NOT be able to withdraw and remain off opioids. Your wife figures that since she did it, you should be able to also. However, 80-90% of those who try to withdraw will return to active addiction within a year--this includes people like yourself who are highly motivated to withdraw.

Unfortunately, your brain chemistry may have been altered to the point that you will never produce the endogenous opioids that normal people do. You are not weak willed; you have a brain chemistry problem. We cannot stress this enough. When you quit taking methadone, your symptoms return, as happens with 80 - 90% of methadone patients. For the other 10 - 20%, many of them will take other drugs or alcohol to relieve the symptoms.

Your wife needs to realize you are an individual, and your body may react differently than hers. And you need to increase your dose to where you feel comfortable. We would hope that she would be open minded enough to properly educate herself about opiate addiction and methadone treatment, before reaching the erroneous conclusion that you are not truly "in recovery" because you are still on methadone (**Ct p. 3**)

ROD Study Finds Delirium Among Other Complications

by Dr. Andrew Byrne, General Practitioner
(New South Wales, Australia)

**Unexpected Delirium During Rapid Opioid Detoxification (ROD), Golden SA, Sakhrani DL. Journal of Addictive Diseases (2004). 23; 1:65-74.*

This is one of the very few descriptions of a series of rapid opioid detoxification (ROD) cases. Many such reports have been anecdotal, coronial or selected cases, and thus of limited scientific value. This Pittsburgh series is drawn from 20 consecutive patients 'requesting' rapid detoxification with an appraisal of their outcomes and complications. Some of these complications are very worrying, and they are not infrequent. Five patients (25%) developed delirium and had to have the procedure abandoned. One of the 5 patients who developed delirium had to be treated in intensive care for hypotension. Another had bradycardia, a problem also reported by the Spanish group with most experience in this area (Sealone et al.). One further patient of this twenty refused to take the naltrexone on day two. Thus an early relapse rate of 30% may be indicated. The average hospital stay was 6 days.

Even though the follow up is patchy (it only lasted for 'the study period', the length of which was not stated), at least 4 (20%) cases had to be readmitted for further detoxification ('traditional', not 'ROD') in the immediate post-treatment period at the same institution while others treated lived at some distance and could not be followed up at all.

These results are extremely poor compared with other reports, but they would appear to be influenced by very high rates of depression, anxiety and other co-morbid conditions, notably the use of benzodiazepines and other drugs in combination with opiates. Also, it is hardly surprising that the patients who were being forcibly reduced from methadone would not do well with an abstinence based treatment.

According to some experts, rapid opioid detoxification is most likely to prove appropriate for a group of addicts who (1) are pure opiate users, (2) do not suffer severe Axis II disorders, (3) who have had beneficial periods of abstinence in the past, (4) who suffer particularly severe EARLY withdrawal symptoms with traditional detoxification AND (5) who are competently assessed as being currently 'equipped' for abstinence. Importantly, this means that it is not a sufficient criterion for rapid detox to just 'not want methadone'. Similarly, few diabetics would choose insulin treatment unless there were no simpler alternative.

Our Advice: ROD is not worth the risks The Editors

We have published many articles and patient stories from individuals who have undergone the procedure regarding rapid detoxification (ROD or UROD) in previous issues. This is just one more study in the long line of research and patient stories documenting the problems with and dangers of "rapid detox". Dr. Byrne concludes with statements about which opiate addicts may be appropriate candidates for ROD, "[a]ccording to some experts," but the 'experts' are precisely the problem in some cases.

ROD is such a profitable treatment, that the practitioners are often less than truthful about the success rate and risks associated with the procedure--and oftentimes, it is these very practitioners that are regarded as the 'experts'. In fact, according to the many patient stories we have received over the years, ROD practitioners profit by selling the procedure to desperate opiate

addicts with far from truthful claims. When ROD first became available in the U.S., some practitioners would tell perspective patients that they would "sleep through withdrawal" and wake up fine except for some mild fatigue, "ready to begin a new, drug-free life." Even now, many practitioners mislead patients and certainly do not tell perspective patients that they may wake up from the procedure in severe withdrawal and unable to walk without assistance.

After all, to profit from RAD, practitioners MUST lie: how many opiate addicts would pay thousands of dollars to undergo a potentially dangerous procedure, where they are likely to wake up quite sick from withdrawal? An opiate addict can make themselves sick for free--never mind that the mortality rate associated with this procedure is actually HIGHER than that of untreated opiate addiction!

So at this point, we would strongly recommend disregarding what any 'experts' say about who would be a good candidate for ROD and simply avoid ROD entirely. There is certainly no evidence that for any subgroup of opiate addicts, including 'good candidates', ROD has a success rate anywhere near as good as that associated with a slow methadone taper or other currently accepted 'detox' methods--and anyone who is worried about withdrawal pain and discomfort should certainly avoid ROD at all costs.

The relapse rate indicated in the above research, while fairly high, does not reflect the true relapse rate, as the follow up was "patchy" and only covered a short period of time. 'The study period' is at most a few months; the relapse rate after one year is a lot higher than after only a few months. Note that in all likelihood, the success rate is even lower using ROD to withdraw from methadone. For opiate addicts not currently in methadone treatment, a slow methadone or buprenorphine taper is a better idea if you're determined to withdraw from all opioids.

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, Director/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, 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.

Enlighten Public (from p. 1).

with the board of directors next week to determine my eligibility even though I successfully met all acceptance criteria. This is madness! What is the suffering addict, who desperately seeks help, to do during the interim? A week seems unbearable, let alone a month. I had to begin treatment in an intensive outpatient/detox program while I wait to be accepted (I pray!).

The reason it's taking so long to get into this program is twofold:

(1) As you mentioned, I must "prove" that I'm a narcotic addict who has had a several year history of opiate addiction. This does not seem to be too difficult to ascertain to me, but I guess they want to be careful. Again, too much governmental red tape.

(2) The intake process consists of first completing some general paperwork. This is followed by an assessment meeting with one of the counselors one to two weeks later, depending upon their schedule. If you still meet the requirements of the program, you then meet with the intake panel for final disposition. Again this can take one to two weeks following the assessment interview. After having successfully completed this, then you meet with the physician who will usually begin treatment that day. The major hassle in all of this is that intakes are only done on certain days of the week, and the number of open slots depends upon the number of applicants at the time. As it is, the M.D. is only available on certain days, and the intake panel only meets once or twice a month, etc.

MMT is the only treatment modality for opioid addiction that makes sense to me. Its neuropharmacological approach to treatment is sound--unlike much of the current psychobabble and inner-child nonsense that is so pervasive in the treatment community today. I simply cannot comprehend the attitudes of treatment professionals and government policy makers alike who scoff at and dismiss MMT only to praise abstinence-only programs despite the fact that MMT is substantially more effective and less costly than abstinence programs will ever be. During my numerous attempts at recovery, at no time was MMT discussed as a potential option. This is truly a disservice to the thousands who needlessly suffer relapse after relapse in abstinence programs and eventually lose hope. When will they ever learn? If methadone was not a controlled substance, I wonder if this disparity in philosophies would exist? If the medical and treatment community truly believes that narcotic addiction is a disease process, why don't they finally treat it as one and end this

inane prejudice and narrow-mindedness? Perhaps this may be one positive outcome of the HIV epidemic. It is sad to think that it takes this kind of motivation to grease the wheels of policy reform in this day and age of supposed enlightenment. Thank you again for your interest, support and helping to break the barriers to responsible and ethical MMT.

My only hope is that the MMT program treats us with some amount of dignity and truly views narcotic addiction as a disease entity, rather than just giving lip service to it. We are not bad people. We are simply sick, with an incurable disease, trying one day at a time to get well. If methadone helps to facilitate this, I cannot ask for more!



Editor's Note: Fortunately, there are methadone clinics where intakes are dosed the same day if they are found to be in need of treatment, as opposed to waiting days or even weeks before treatment is initiated. Assuming the treatment provider has treatment slots available, there is no good reason why an intake cannot be medicated the same day. One exception might be an otherwise eligible opiate addict may be turned away if s/he is intoxicated at the time of intake. Some states may have regulations requiring a waiting period of a certain number of days before a new intake is dosed, although we are not aware of any. If this is the case, however, hopefully policymakers in such states will realize the error of such requirements and amend the regulations accordingly.

President's Speech (from p. 1).

patients normally have to have certain education/credentials, but under the "Faith-Based Initiative", providers of faith-based treatment could employ staff without such credentials to counsel patients. Perhaps the President should spend less effort giving special treatment to providers with the agenda he prefers and more effort ensuring that scarce, woefully insufficient federal funds are at least devoted to programs which provide the most effective drug treatment modalities, thus maximizing the benefit to individuals suffering from drug addiction.

It is criminal that the majority of opiate addicts do not have access to opiate agonist treatment (i.e., methadone treatment)--by far the most effective treatment for opiate addiction--while "faith-based" programs similar to Teen Challenge (see the June Issue of *Methadone Today*, "Faith-Based Treatment--My Bad Experience") receive government funding to provide what is not even a real treatment for drug addiction.

Finally, President Bush's statements only serve to perpetuate the public's misunderstanding of drug addiction. Such statements reinforce people's belief that drug addicts are immoral and weak willed, rather than simply being the victim of a medical condition.

If Bush would really like to help those suffering from drug addiction, he should be saying that addiction is a medical disease and not the result of a lack of morals, willpower or religious conviction. Maybe then the public would stop viewing drug addicts as immoral criminals and decide that ensuring drug addicts have access to treatment should be a higher priority than incarcerating addicts.

Dear Ray (from p. 1).

and that you could detox off of methadone and remain opioid free if you really wanted to. Your wife should realize that methadone treatment has helped you live a functional life without using illicit drugs.

By the way, we hate the term "clean." It implies that anyone taking a medication is "dirty." If you were taking insulin to control the symptoms of diabetes, no one would refer to you as "dirty". Don't fall into that trap. Methadone is a life-saving medication that seems to have helped you for 20 years. The medication does the job it is supposed to do--control the symptoms of your disease.



Dear Methadone Today,

Being on methadone and my experience with the clinics leads me to believe many clinics are in it for the money. It seems they do not want anyone to get off methadone. I would think if you had many more people that got on methadone and got off it within a short period of time (maybe a year or less) you could use those cases to show the people who are against methadone. I heard when methadone maintenance first began it was for use for ONE month or SIX months. I know people who have been on methadone for more than ten years. I agree that some people should stay on methadone (maybe forever)--I am just talking about the people that do not have a long history of abusing opiates. I'm sure [some] counselors want to help people, but with so many clients or paperwork, sessions are spent talking about the weather.

Let me just say that I am not against methadone--nobody should be--but it seems when you become a client, they [the methadone clinic] want you for life.... -Steve

Dear Steve,

We do agree with you that many methadone clinics are primarily in it for the money. But we do not find that clinics preventing patients from withdrawing from methadone is a common problem. In fact, in many areas of the U.S., there are waiting lists to get into methadone treatment--in such cases, providers are not the least bit worried about losing some patients because they withdrew from methadone, as there is always someone else to fill the slot.

It may seem counter-intuitive, but there seem to be more treatment providers guilty of pressuring patients to withdraw from methadone than those that pressure patients to remain on methadone. Nevertheless, you are not the only one that has suggested that methadone clinics try to keep patients on methadone because it is in their financial interest to do so.

In many cases, patients are discouraged from withdrawing from methadone because the doctor or counselor believe that they are not ready to do so. Clinic staff are quite correct to advise a patient against withdrawing from methadone if, for example, the patient is regularly drinking alcohol, using drugs (opiates as well as other drugs, like cocaine), or still reporting drug cravings. Even in the best circumstances, the odds are NOT in the patient's favor that s/he will withdraw off of methadone without

subsequently relapsing (80-90% will relapse in one year)--the patient should be warned by clinic staff of the risks of withdrawing from methadone, and staff should definitely recommend against withdrawal if certain factors make relapse very likely or imminent.

As we have discussed in previous issues, methadone maintenance patients are not "addicted" to the medication, so treatment "success" or "failure" is not measured by whether the patient withdraws from the medication or remains on it for a lifetime. By the way, it is not true that, "when methadone maintenance first began it was [intended] for [short term] use," though this was the philosophy of many early methadone clinics; however, prior to the original methadone maintenance trials, methadone had been used on a short term basis to "detox" opiate addicts, but the relapse rate was quite high. (If you would like to read what Dr. Vincent Dole, "the father of methadone maintenance," has to say about this, see the February 2004 issue of **Methadone Today**, "An Interview with Dr. Vincent Dole (part 1).") The nature of opiate addiction is such that only a small minority of addicts are able to remain opioid-free and functional long term without methadone.

Opiate agonist treatment (i.e., methadone) allows opiate addicts to function without abusing short acting opiates--stable methadone patients experience neither intoxication nor withdrawal and do not have to contend with the potential harmful side effects of addictive opiate use (i.e., overdose, vein damage or contraction of blood borne diseases like HIV and hepatitis C, criminal prosecution for purchase, possession and use of illicit or controlled drugs, etc.). To use the common analogy, methadone treatment for opiate addiction is comparable to the administration of insulin in the treatment of diabetes. Diabetics are not "addicted" to insulin any more than methadone patients are addicted to methadone--in both cases, the medication allows the patient to live a normal, functional life.

Please do not take this constructive criticism the wrong way. We appreciate your letter and strongly welcome and encourage readers (not just patients, but also treatment provider staff, friends and family of patients, etc.), to write a letter or article to us. You certainly have a point that treatment at many methadone clinics leaves something to be desired. As you allude to, counseling is one particular area that could use improvement at many clinics--often, resources are wasted by one-size-fits-all requirements, resulting in some stable patients receiving totally unnecessary counseling sessions, while others do not get enough time with their counselor. But there are other problems, like counselors that are not properly educated regarding opiate addiction and opiate agonist treatment. We will continue to advocate for better and more accessible opiate agonist treatment.

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