

Methadone Today

The official newsletter of DONT--BY PATIENTS, FOR PATIENTS August 2005 Volume X Number VI

'I was a drug addict', Whether to tell

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The process of rehabilitation involves many tasks for the client and his therapist. After the first goal reached, which is abstinence, the client has to learn how to live without drugs. Being 'successful' means solving every-day problems without the help of drugs. Motivation alone is not sufficient to reach this goal. The client needs appropriate techniques to face the needs of every day life, which not only implies changing things on a personal level, but also learning new psycho-social skills.

The major area is the relation the ex-drug addict has with other people. One of the important questions which rises in this period is whether or not to say that I was a drug addict. Sometimes, the client and therapist don't give this issue sufficient attention. "Why should one give so much attention to this question?" one could ask. We think that this question defines the position of the client towards himself and his past life. If this position is clear and well defined, the person could find in it the support he needs for the every-day confrontation with known and unknown people who want to talk about his past.

In the process of rehabilitation after the period of drug abuse there are many situations in which the drug addict is confronted with the dilemma of saying or not he was a drug addict. Sooner or later the person is faced with people who do not know about his drug history. These persons could be his new employee, new partner, new friends etc. What will their reaction be? Maybe they will find out from other people? Is it better that they find out from me? Maybe, if I tell them, I will lose my job, partner, or my new friends? Am I obliged to tell everything about myself? In many cases, the result of talking openly about this problem is just the opposite of what one has expected; sometimes the reaction is very positive—in some cases negative.

What should the therapist advise? I think it is the therapist's job to teach the ex-addict how to explain his problem and teach him how to accept the reactions of people who discover the "news".

There is a difference between telling a new partner and a new employer. If the ex-drug user wants a sincere relationship, he should find a mode of telling the 'news' in such a way (**Cont. p. 3**)

Dear Methadone Today,

I am an ER Physician working in Southeastern Ohio and am getting increasingly frustrated by so called "methadone maintenance". I see numerous patients on a fairly regular basis who are having opiate withdrawal symptoms.

Although each case is different, the story goes something like this. I am tired of being on methadone and want to get off. I have tried to talk with my counselor at the methadone clinic and have them change my dosing so I can wean myself off the drug, but they don't think it is a good idea. I decided to stop going and haven't had any methadone or any other opiates for 8 days. I am getting increasingly anxious, I'm not sleeping, and I don't know what else to do. My response to this rhetoric is this: Why don't you go back to the methadone clinic? I hear all kinds of responses to this, but they generally center around the fact that it is a weekend, or a holiday, or they simply have lost faith in the clinic. On further query I ask them what dose they started out on. "I started out on 30 mg a day but over the last two or three years it has increased to 300 mg/day. Am I the only one who see's a problem with this?"

This isn't maintenance therapy! It seems to me that we're escalating an addiction. I am writing in hopes someone might explain the rationale behind this. Is this common practice? Should the DEA be raiding more of these clinics? Please help me to understand.

I would very much appreciate a response to this.
Sincerely,

Derek Hollingsworth D.O.

Dear Dr. Hollingsworth,

Thank you for writing in. First of all, when you ask patients what dose they started on, we are not sure the answer that you want. If you mean literally what dose was given the very first day of methadone treatment, the answer is usually going to be 30 mg. 30 mg/d is seldom sufficient to stabilize an opiate addict. The reason such a low initial dose is used is because it is ©. **p. 3**)

Dear Methadone Today,

I am writing to thank you for putting out a most informative newsletter and to relate something I overheard at my methadone clinic which I found distressing. Let me stress that I did not intend to eavesdrop on someone else's private conversation--I simply happened to hear the conversation because the door to the office they were in was open.

The conversation was between a counselor and a new patient. This was apparently the first time the patient met her counselor. The patient was explaining to her new counselor that she could not make it to the group counseling sessions because she had unusual work hours. The counselor's response was basically that the patient had come to the wrong place [if she could not make it to one of these group sessions]. Eventually, they did figure out one group session that was held a different time of day that the patient probably could make.

Nonetheless, I did not like the tone taken by this counselor. Instead of trying to figure out a solution to the problem, her immediate reaction was 'too bad'. Counselors like her behave like they are doing

their patients a favor, when it is the counselor that is getting paid to do a job--and her salary comes from the weekly fee patients pay for treatment.

Furthermore, isn't the purpose of methadone treatment to help patients achieve a normal, functional life without abusing illicit drugs? Part of a functional life is gainful employment. Surely, patients should not have to quit their job to be able to remain in treatment. If this patient indeed could not make any of the group sessions offered, why couldn't alternative arrangements be made? Maybe the group counseling requirement could be waived as long as she promptly attends all her scheduled individual counseling sessions and progresses well in treatment. Or, the group counseling requirement could be waived provided that she attends some sort of outside meetings (i.e., NA meetings). Even better would be if group sessions were offered at different times of the day to accommodate patients with different work hours--though I doubt that the methadone clinic would be willing to do that.

I guess I just have a problem with the whole (**Cont p. 2**)

Dear Methadone Today (from p. 1).

attitude of such counselors. A counselor is supposed to be helping patients in their recovery, not behaving like a parole officer. I should add that there are many good counselors at my methadone clinic--I am not saying that this particular counselor is representative of methadone clinic counselors at my clinic or in general. **-Distressed**

Dear Distressed,

We completely agree with you. We believe that this counselor should have made some effort to find a workable solution before getting such an attitude. As an aside, we would like to see more methadone clinics have flexible hours to accommodate patients' work schedules--even if they work afternoons, nights, or odd hours.

Although we do not know the patient's individual problems and circumstances, we are skeptical of methadone clinics that require all patients to attend group counseling. Counseling needs--particularly when it comes to group counseling--should be individually determined for each patient. Some patients do not need group counseling or do not find group counseling beneficial.

Canadian Research Study Examines Withdrawal Symptom Severity in Rapid Detox Patients

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

Measurement of Symptom Withdrawal Severity in a 24-Hour Period After the Anesthesia-Assisted Rapid Opiate Detoxification Procedure. Teplin D, Raz B, et al. American Journal of Drug and Alcohol Abuse (2005) 31;2:327-335.

These authors from Canada should be commended for joining the small group who report aspects of outcomes after commercial rapid detox procedures. However, the only outcome reported here is a clinical withdrawal rating at 1 and 24 hours after the rapid detox procedure in 40 subjects, 70% of whom were dependent on heroin and/or methadone. It is not clear if they were consecutive or chosen in another manner, 'retrospectively'. Seventy five percent of subjects were Caucasian with the remaining 25% Asian.

In this seven page article, the 'results' section takes eight lines, using the somewhat clumsy wording: "The average [withdrawal score] for the group supports lowered symptoms over a 24-hour period. For 5 out of 40 patients this was not the case; that is, their change scores were negative, which indicated increased withdrawal symptoms". So, as well as for some whose symptoms became worse over 24 hours, another proportion would have had no significant change in withdrawal ratings, yet these are lumped with the former 35 of 40 subjects given the procedure. It is disappointing that the authors do not apparently trust readers with the raw data, even in a graphic form, giving only a block table of averaged scores.

Prospective patients, families and others may be disappointed that a novel, expensive treatment for a chronic condition is only examined for one single day in this publication. It may reflect a prevalent view that some such facilities are less interested in the long-term outcomes than in performing the procedure and 'moving on'. This institution has done more than most by publishing a series of outcome findings in a peer reviewed journal.

I have looked up the institution on a web search and found two matches. One quotes a figure of \$5300.00 (Canadian) for a procedure [http://www.westerndetox.com/price.html accessed 16/7/05], while the FAQ [Frequently Asked Questions] site is 'under construction' which would be something of a disappointment for prospective addicted candidates [http://www.canadadetox.com/English/faq.asp accessed 16/7/05].

Another of the linked pages states "As it stands now, 6-8 out of 10 patients who are detoxed successfully will relapse in the first six months, back to their drug of choice. In an effort to dramatically improve those numbers, our centre encourages that all patients participate both in the Naltrexone Pellet Maintenance Program and a structured aftercare program conducted by an addiction specialist." [Thus the suggested treatment will cost more if the naltrexone 'pellets' are chosen.]

Thus because the procedure has such a poor reported success rate, the clinic advises an untested and unregistered sub-cutaneous drug treatment as an optional 'add-on'.

Everyone in the field knows how earnestly many of our patients are seeking abstinence. It may be this factor which clouds some people's judgment and fuels the use of expensive and unproven approaches. The first unhappy reports of rapid detoxification for opiate addiction were from 1899 [MacLeod, N. Cure of morphine, chloral, and cocaine habits by sodium bromide. Brit Med Journ (1899) 15/4/1899 p896]. The procedure may well be appropriate for some candidates but until some selection criteria are reported with outcome results, we will remain in the dark.

Editor's Note: We remain unconvinced that rapid detox or UROD is a procedure worthy of serious consideration. Part of the problem with this research is that they are measuring withdrawal severity in comparison to no treatment (e.g., 'cold turkey' withdrawal). The real question is how rapid detox compares with other methods of opiate withdrawal.

It may very well be that withdrawal symptoms can be better managed with non-opioid medications like clonidine and benzodiazepines. Better yet, a short-term or long-term methadone or buprenorphine taper seems to be the best way to go. At best, rapid detox is a gamble.

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

Our Medical Advisory Board includes:

Dr. Vincent Dole;

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.

Dear Dr. Hollingsworth (from p. 1).
impossible to determine opiate tolerance level--especially if the patient was using heroin (an illicit drug of unknown purity). Starting at 30 mg and gradually increasing the dose as necessary ensures that the patient will not be overdosed. When increasing the dose at a gradual rate, it can take awhile for a patient to reach an adequate dose. What the 'adequate dose' will be depends upon the individual. For a large majority of patients, it is 80-120 mg/d, but in some patients it will be lower or higher. In a small percentage of patients, it will be much higher. Note that many factors, beyond the amount of opiates the patient was using prior to treatment, play into what is considered an adequate dose. Thus, one methadone patient's dose may be 50 mg/d, another 300 mg/d, and both could be at their optimal dose.

To many doctors and lay persons, it may seem to be common sense that methadone patients should be prescribed as low a dose as is possible--as to avoid, "escalating an addiction" and to make it easier to withdraw from the medication (we avoid using the word 'detox' because it is inaccurate and suggests that methadone treatment is somehow 'toxic'). However, a mound of research over the years indicates that a low dose regimen is not a good idea--as counterintuitive as that sounds.

Study after study demonstrates that low dose practices are associated with poor outcomes. Methadone patients on sub-optimal doses are likely to continue to abuse opiates, as well as other drugs (i.e., alcohol and benzodiazepines). An adequate methadone dose should not only prevent the onset of opiate withdrawal symptoms but should also alleviate drug cravings.

I cannot tell you the dosing practices of every methadone clinic, but as a general rule, clinics are not known for overdosing patients. In fact, under dosing is still far too common. You quote a patient as stating that their dose is 300 mg/d. It is difficult to find many methadone clinics willing to prescribe anywhere near that, and I am speaking of those cases where such a dose is called for. Many clinics are reluctant to prescribe over 100-150 mg/d and will at least require a methadone blood plasma test before increasing patients to such a dose. Methadone clinics should NOT be reluctant to prescribe a relatively high dose, where appropriate. Forget about the numbers;

the question should be whether the patient is stable, functional and illicit drug free.

As for this business about "escalating an addiction," the important point to remember is that there is a difference between 'addiction' and 'physical dependence'. An individual could be addicted to a drug but not physically dependent on it. Conversely, an individual could be physically dependent on a drug, but not addicted to it. The classic example of a person who is physically dependent but not addicted is the long-term or chronic pain patient. The patient is physically dependent on opioids; that is, if the individual abruptly stopped taking the pain medication, they would experience withdrawal symptoms (i.e., diarrhea, chills, runny nose). However, this patient is most likely not addicted to the pain medication. Addiction implies a whole other set of behaviors. A person who is addicted and stops taking the medication will experience drug craving or a compulsion to use the drug, and they will have obsessive thoughts about using the medication.

This is the precise reason why methadone maintenance is a medical treatment. Methadone patients are not 'addicted' to the medication. In fact, once stabilized at the proper dose, they experience very little or no intoxicating effects from the medication. After being on a given dose for a period of time, the patient becomes completely tolerant to methadone's analgesic effects. One of the major reasons opiate addicts have such difficulty functioning is that much of the time they are either intoxicated or in withdrawal. On the other hand, methadone patients are able to function because, once stabilized at an adequate dose, they are 'normal' throughout the entire day--the medication prevents the onset of withdrawal symptoms but does not intoxicate the patient.

Finally, we are concerned about some of the patients you are referring to that are trying to withdraw from methadone by abruptly stopping the medication. Methadone patients who abruptly stop taking their medication are at extremely high risk of relapse. Gradually tapering off methadone is a safer method with a higher probability that the patient will successfully withdraw from the medication without relapsing to illicit opiates or other drugs. But even then, the probability that the patient will relapse within a year of withdrawing of methadone is statistically high (80-90%). For this reason, patients who are not stable and abstinent from

drugs of abuse should be advised against withdrawing from methadone. Maybe this was the reason that their counselor, "didn't think [withdrawing was] a good idea."

Too often methadone clinic staff and counselors push patients to withdraw from methadone. The general philosophy is that withdrawal should be the eventual goal of treatment for all patients. We disagree: in a **Methadone Today** interview, Dr. Vincent Dole, who along with Dr. Marie Nyswander, conducted the original methadone maintenance trials and is regarded by many as the father of methadone maintenance treatment, stated that the goal of methadone treatment is to become functional, not to become abstinent from methadone. Some opiate addicts apparently have a permanent physiological imbalance and will never be functional without remaining on opiate agonist treatment. Methadone patients who remain on methadone maintenance indefinitely and have a normal, functional life, are no more 'treatment failures' than a diabetic who has to take insulin for the rest of their lives.

Whether to tell (from p. 1).

as to avoid rejection. He has to consider that his new partner would like to know if (s)he is coming into a relationship with a healthy person. We have to consider HIV, hepatitis and other infectious diseases. In this respect, ex-drug users should be taught how to act in a responsible and effective manner. However, if the ex-drug user is faced with his new employer, there is no need for him to give any personal details about his past.

We would like to print your story--how your life changed when you got into treatment.

If you have had a good or bad experience with your clinic, we would like to hear about that too.

And, of course, we always like to receive your comments about the newsletter.

Dear Methadone Today,

I recently switched from 85 mg of methadone to Suboxone (the brand name for buprenorphine). My reason for doing this is because I am a truck driver, and methadone is the only legal drug that is illegal to use when driving a truck for the Department of Transportation (DOT).

I had a rough time at first. I was required to withdraw from methadone 5 mg every two weeks until I was down to 30 mg; then I had to go three days without anything. The first couple of days weren't too bad, but the last two days were complete "hell." I had bad withdrawal pains, high blood pressure, leg and joint pains, and I believe my blood sugar was out of whack. The worse thing was insomnia; I didn't sleep for three days.

The first day on Suboxone, I was only given 4 mg, twice a day. This didn't do much good. I still had withdrawal symptoms. The second day, things got better because I was given 4 mg, four times a day, but I still didn't have energy. After about four weeks, I stabilized on 4 mg, five times a day.

I'm 51 years old, and it was a lot harder for me than another patient I met who was only 24. I was on methadone for ten years after a 20-year drug habit. Methadone probably saved my life, but since I've been on Suboxone, I no longer sleep as much, I don't sweat profusely, and my joints don't ache. I know they claim methadone doesn't cause aching joints, but I believe it did with me. I no longer crave sweets, and my sex drive has come back.

The negative points of Suboxone: I'm probably not sleeping enough, and the medicine is a hassle to take subcutaneously because it takes a long time to melt under the tongue. Also, Suboxone is quite expensive—over \$5 for an 8 mg pill. My insurance is paying for the pills now (they also paid for methadone), but I don't know how long they will keep paying.

I really enjoy your newsletter, and keep up the good work. **-Anonymous Truck Driver**

Dear Anonymous Truck Driver,

We are aware of the DOT regulations that you refer to which ban truck drivers from taking methadone for legitimate medical purposes. This particular provision has obviously been around for a long time--back when methadone treatment was relatively new and much of the large quantity of research that has since been accumulated had not been conducted yet. This provision probably should not have been written in the first place,

but it certainly should be repealed now.

We will not cite the research here on the issue of whether methadone impairs driving, but suffice it to say that all the research unequivocally demonstrates that methadone does not hinder the stable methadone patient's ability to drive or operate heavy machinery of any kind. Regulators can offer no reasonable justification why methadone patients should be automatically excluded from driving a truck.

The approval of buprenorphine [Suboxone] for the treatment of opiate addiction has allowed truck drivers to obtain opiate agonist treatment and still continue to drive trucks. In addition, the relatively lenient regulations for buprenorphine treatment allow patients--even those just starting treatment-- to go to a doctor just once a month and obtain a month's supply of the medication at a time. This is an especially big deal for truck drivers who often work irregular hours and may only be in their home town once or twice a month.

That being said, buprenorphine treatment has some limitations as a medical treatment. Buprenorphine is not identical to methadone. Some opiate addicts will not do well on buprenorphine treatment. The main limitation of buprenorphine is that [at most] it is only comparable to about 60 mg/d of methadone. We will not go into the explanation here of why this is, but the end result is that a large minority of opiate addicts will not be as satisfied with buprenorphine as with methadone and may even relapse to illicit opiates or other drugs as a consequence.

Fortunately, it sounds as if you are doing pretty well on buprenorphine treatment. We are glad that it is working so well for you. As you allude to, a large percentage of opiate addicts cannot afford buprenorphine treatment. Put simply, buprenorphine is very expensive relative to methadone because the pharmaceutical company that markets and distributes it (Schering Plough) has a patent on the medication (i.e., no generic version of the drug is available). In contrast, methadone has been on the market a very long time, and the patent ran out ages ago, so any pharmaceutical company can sell a generic version of the medication; thus, companies have to compete and cannot charge an exorbitant amount for the medication. When the patent runs out on buprenorphine, it will be available at a reasonable price.

Thank you for writing in, and we wish you continued success in treatment.

We urge other readers to write in about their experience with buprenorphine and/or how difficult it was to transfer to buprenorphine from methadone.

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