

Methadone Today

The official newsletter of DONT--BY PATIENTS, FOR PATIENTS

March 2005

Volume X Number III

NIMBY Sentiment Leads to Court Battle

If anyone needs proof that the, "Not In My Backyard" (NIMBY) mentality is alive and well, one only needs to look at the battle going on in Rockland, Maine, over a proposed methadone clinic. The Rockland City Counsel amended the zoning laws in December 2004, upon learning that a methadone clinic was to be opened up in the city. The zoning amendment essentially made it impossible for a methadone clinic to open and operate within the city.

The prospective owner of the methadone clinic has apparently been willing to come to a compromise regarding the facility's location, etc., but the Counsel refuses to budge. All along, vocal city residents have been urging the City Counsel to keep the proposed methadone clinic from opening and operating in the city. At this time, a courtroom battle appears to be inevitable, but the expense to city taxpayers has not deterred the City Counsel from blocking the proposed methadone clinic.

Twenty years ago, the prospective methadone clinic owner would not have any recourse if the city blocked them from opening a methadone clinic. But the passage of the Americans with Disabilities Act (ADA) has given methadone treatment providers--and by extension, methadone patients, a legal means to fight municipalities that attempt to block or excessively restrict the location of methadone clinics. Although the ADA primarily deals with employers and the treatment of employees, it also covers municipalities (i.e., city and county government). Just as the ADA is designed to prevent discrimination against employees with certain disabilities, it has also been construed by the courts to prevent municipalities from adopting and enforcing zoning ordinances that effectively discriminate against people with certain disabilities. In the case of methadone clinics, the ADA prohibits municipalities from enforcing zoning ordinances that discriminate against opiate addicts.

The courts have generally allowed municipalities to place 'reasonable' restrictions on the location of methadone clinics. For example, a city or county may require that methadone clinics be located at least two blocks from any grade schools or day care centers. However, courts are apt to strike down (**Cont. p. 3**)

Dear Methadone Today,

I am not sure if you will have the answers to my questions, but every other place I have looked online has been an advertisement for an expensive rehabilitation center.

After 9 months of methadone maintenance, I have decided I am ready to attempt to overcome my dependency on methadone. I have taken a daily dose of methadone for a longer duration of time than I injected heroin (gram a day habit for about 6 months). The clinic I go to is reducing my dosage by 10 mg a week and will slow it down to 5 mg a week once the dose is below 50 mg.

I am hearing conflicting information about the level of physical and psychological distress I can expect. I have read repeatedly that methadone readily stores in the body's tissues, making the detoxification process slow and complicated. I have been told that cravings may persist for years afterward due to these toxins remaining in the fat cells and such.

I have been searching and searching the internet for information on how to best assist my body with this cleansing process and am finding nothing but ads for numerous rehabs who claim they can do this for you. Any suggestions on where I can turn for free information or tips to increasing the success rate of methadone detoxification? Thank You. **-Melanie**

Dear Melanie,

As you may have figured out by now, there is no easy, highly effective method of 'detoxification'. As we have repeatedly stated, this is not a shortcoming of methadone but is instead the nature of opiate addiction. If long-term abstinence from all opioids were fairly easy for the majority of opiate addicts to achieve and maintain, fewer opiate addicts would require opiate agonist treatment (i.e., methadone treatment), and the relapse rates for opiate addicts in 'abstinence-based' treatments would be much lower.

Though we have educated ourselves and consulted with doctors quite a bit, we are not doctors, so keep in mind that we are not giving you advice. Rather, the following is true only (**Cont. p. 3**)

New Resource--Georgia ARM Website

To access the Georgia ARM web site, direct your browser to <http://www.medicalassistedtreatment.com>. This is a wonderful resource. It has everything! And more to come.

I am especially impressed with the legal section, which everyone should take the time to read. As methadone patients, I think all of us have given some thought as to what would happen to us if we were incarcerated. Most jails will not give patients their medication, but there may be remedy through the law. You will find out how in the "legal issues" section. We all need to be prepared in case the unthinkable happens.

So, do yourself a favor and check

My Clinic

Many patients gripe about their clinics, and there is usually good reason for it. However, I have nothing but praise for Bio-Med and my treatment there. From those at the front desk, all the way up to the doctor, there is a positive atmosphere in the clinic. Patients are not looked down on or made to feel somehow unworthy because we take methadone.

This may sound silly, but little things say a lot. Bio-Med puts Charmin **Ultra** toilet paper in the patients' bathroom. That's just one of the little things they do for patients. I notice.

Treatment is individual, based on science and clinical assessment. There are no arbitrary dose ceilings. No blind dosing.

If your clinic isn't up to par and you live in Michigan, give Bio Med a call at (586) 783-4802.

Research Study Examines Anti-Depressant Effects of Methadone/Buprenorphine

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

Depressive symptoms during buprenorphine vs. methadone maintenance: findings from a randomised, controlled trial in opioid dependence. Dean AJ, Bell J, Christie MJ, Mattick RP. European Psychiatry. 2004 Dec;19(8):510-3.

This well conducted double blind, randomised study examined psychiatric symptoms used the Beck Depression Inventory (BDI) in a subgroup of consenting patients seeking maintenance treatment for opioid dependence.

There were 54 subjects who were each tested at entry and at 3 months into treatment. While we are not told the proportion who had depression, the mean BDI dropped from 22 (± 10) to 12 (± 10) in methadone patients and 25 (± 11) to 13 (± 9) in those on buprenorphine. By my calculations, the methadone patients saw a mean reduction of 48% in their severity while for buprenorphine, it dropped by 46%.

We are told that the difference between the groups was not significant and that larger studies would be needed to determine if there is actually any difference. In my view, any residual difference would be modest, and other factors would probably prevail in clinical decisions about which drug to prescribe. While a BDI reading of 22 would only indicate a moderate depression individually, these are mean figures with standard deviation of 10 so there must have been a number of severely depressed subjects in each group. The mean doses (for third month) were 48mg (± 20) for methadone and 9mg (± 4) for buprenorphine. Both would probably be considered lower than optimal although they are higher than in a number of other quoted reports.

Thus the conclusion should be that both methadone and buprenorphine treatments are associated with dramatic reductions in overall depression symptoms in the first three months of maintenance treatment. Some still warrant specific antidepressant treatment and indeed, one in ten had been prescribed such drugs during the study period. This is likely to improve retention and reduce illicit drug and/or alcohol use.

The authors state: "The reasons for improvement include both pharmacological and psychosocial stabilisation and may also reflect poorer retention rates for depressed subjects". This latter seems inconsistent with their finding that 'Baseline BDI scores ... were not predictive of treatment retention'.

It is always gratifying to have ones long-held clinical impressions confirmed by controlled scientific research. While the comparative findings may be novel, the observations about depression are not. Several relevant references are over 20 years old. We should all be reassured to learn that both methadone and buprenorphine treatments are probably equally effective in addressing symptoms of depression. This finding supports the general therapeutic practice (in countries where both drugs are available in normal practice) that methadone is the more common first line drug and buprenorphine is used very successfully for those who are unable or unwilling to take methadone. As with naltrexone (and probably any other drug), doctors who preferentially use buprenorphine will often find limited results with a proportion of patients, notably those with high tolerance, who may later transfer successfully to methadone or other treatments.

Research--Opiate Agonist Treatment Cuts Rate of HCV Infection

by Dr. Andrew Byrne, General Practitioner

Hepatitis C virus incidence among injecting drug users on opioid replacement therapy. Hallinan R, Byrne A, Amin J, Dore GJ. ANZ Journal Public Health (2004) 28;6:576-578.

At last there is some good news about hepatitis C. In an article published this week in the ANZ Journal of Public Health we have shown that the incidence of HCV can be kept very low in drug users who are in treatment (with methadone or buprenorphine). While much of the recent information about this virus shows continued sero-conversions as being the rule, this study shows that by using treatment consistent with established guidelines, such cases can become exceptional. In fact, it was our experience that nearly all of the few cases of sero-conversion were in patients who had had their treatment interrupted and/or had been placed in custody for a time.

Between January 1996 and July 2003 54 treatment entrants were initially HCV negative. In the study period 5 sero-conversions occurred, yielding in 131.1 person years (py), an incidence of 3.8/100 py (95% CI 1.2 - 8.9/100 py). Four sero-conversions occurred in the sub-group with interrupted opioid replacement therapy (n=20) during a total of 54.2 py, an incidence of 7.4/100 py (95% CI 2.0 - 18.9/100 py). One sero-conversion occurred in the sub-group with continuous opioid replacement therapy (n=34), during a total of 76.8 py, an incidence of 1.3/100 py (95% CI 0.03 - 7.3/100 py).

The conclusion states: "HCV incidence among IDUs receiving opioid replacement therapy in our clinic was relatively low. Those IDUs without interruptions to their treatment appeared to be at particularly low risk of HCV infection. These findings further support the role of opioid replacement therapy in HCV prevention for IDUs."

Editor's Note: As Michigan and other states attempt to manage budget shortfalls by slashing Medicaid, policymakers ought to consider the long term costs of cutting health care coverage to the poor and disabled, especially when it comes to methadone maintenance treatment. This and other research suggests that if Medicaid no longer covers methadone treatment, the end result will be more cases of Hepatitis C. The state will then be forced to foot the bill for treating these individuals for Hepatitis C. This is to say nothing of the human cost.

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.

Court Battle (from p. 1).

zoning restrictions that are designed to or have the effect of preventing methadone clinics from opening and operating anywhere in the city. Just as employers have to provide "reasonable accommodations" to employees with recognized disabilities, municipalities must accommodate opiate addicts attempting to obtain methadone treatment.

As opiate addiction becomes a more widespread problem, these court battles appear to be growing more common. People residing in middle class suburbs seem particularly resistant to the opening of methadone clinics in their cities. Many of these individuals do not want to admit that opiate addiction exists in their cities--they either think that methadone clinics should not exist at all or should be confined to big cities and lower income areas.

In the ideal world, these people's minds could be changed by education and persuasion. Excuse the catch-phrase, but the opening of a methadone clinic in a city where opiate addiction is a serious problem and no methadone clinics yet exist is a 'win-win' proposition. Given the mountain of evidence demonstrating that methadone treatment is a highly effective opiate addiction treatment and the lack of effective treatment alternatives, there is no question that opiate addicts benefit from the opening of a methadone clinic, especially where no other methadone clinics exist. However, a methadone clinic is also likely to benefit city residents--perhaps the city residents that vocally oppose the opening of a methadone clinic would realize this if they would just take an open minded look at the facts about opiate addiction, methadone treatment, and research concerning methadone clinics and crime rates. Unfortunately, there is still much fear that surrounds this issue, and many people are just not prepared to take an open minded look at methadone treatment and opiate addiction in their communities.

Thus, until everyone can get past the 'Not In My Backyard,' fear-based mentality, methadone clinic owners and patient advocates may need to rely on the courts to combat discrimination and ensure that effective opiate addiction treatment is available to those who need it.

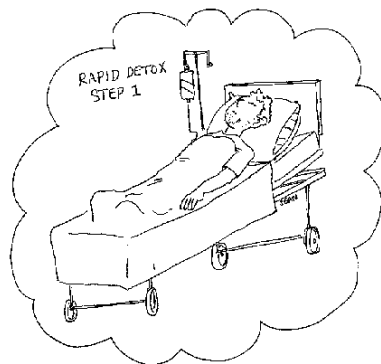
Dear Melanie (from p. 1)

in general. So, please, consult with your doctor--he should be able to give you some more guidance.

Among methadone patients, a gradual taper is generally the best method of withdrawing from methadone. Now that buprenorphine is available in the U.S., some doctors will gradually taper methadone patients down to a dose low enough to permit switching the

patients over to buprenorphine. Then, once the patients are stabilized on buprenorphine, they are gradually tapered off of buprenorphine. Thus far, there is no evidence that transferring from methadone to buprenorphine and subsequently tapering off buprenorphine results in less discomfort or yields a higher success/lower relapse rate than simply tapering off of methadone.

Also, we would definitely discourage methadone patients from attempting to abruptly stop taking their methadone dose (AKA: 'cold turkey' withdrawal) or to withdraw from methadone by undergoing rapid detox/UROD (Ultra Rapid Opiate Detoxification). Needless to say 'cold turkey' withdrawal is painful, and the probability of maintaining long-term opiate abstinence is extremely low. And given the patient stories of their experiences with rapid detox/UROD, we would advise opiate addicts and especially methadone patients to avoid this expensive, inhumane, and potentially dangerous procedure at all costs. For various reasons, UROD seems to be



even more problematic when performed on methadone patients than on current abusers of short acting opiates (i.e., heroin). Methadone patients and opiate addicts generally should be skeptical of UROD--we would especially urge individuals to be suspicious of UROD practitioners that make unbelievable claims (i.e., "when you awake from UROD, you will only experience very mild withdrawal symptoms and fatigue,") or tout extravagant success rates (i.e., "75% of individuals that undergo UROD are opiate-free one year after treatment").

Because methadone is a longer acting drug than short acting opiates like heroin, the withdrawal relative to heroin is typically of longer duration but less intense. But remember that we are not talking about 'cold turkey' withdrawal from heroin vs. 'cold turkey' withdrawal from methadone--rather, you are gradually tapering off methadone. A slow taper isn't going to trigger the kind of

severe withdrawal symptoms that 'cold turkey' withdrawal would.

While we are on the subject of a 'slow taper', 5 mg/week may be too rapid. Of course, individual adjustments should be made as needed, anyway. So, if you start feeling too ill, you should temporarily stop decreasing the dose--in fact, you may need to get a small dose increase. Then, when you feel better, you can resume the taper. As far as the rate of the drop is concerned, it is the percentage decrease that counts, rather than the actual number of milligrams. For example, a 4 mg decrease is fairly small for a patient on 120 mg/d (3.3% decrease), but would be a large drop for a patient on 20 mg/d (20% decrease).

Some of what you are reading is not accurate--especially this business about "toxins". We do not like to even use the terms "detox" or "detoxification". These terms were coined a long time ago, when it was mistakenly believed that withdrawal was caused by an accumulation of "toxins" in the body. This is false. So what you were told, "that cravings may persist for years afterward due to these toxins remaining in the fat cells and such," is inaccurate. It is true, "that cravings may persist for years afterward," but for entirely different reasons. SOME opiate addicts do continue to crave opiates for years after



achieving opioid abstinence--but this is the case whether or not an opiate addict was ever in methadone treatment. Opiate addicts suffer from a physiological chemical imbalance in the brain. In some individuals, this imbalance may correct itself after being free of short acting opiates for a period of time, but it appears to be a permanent problem in many opiate addicts. For this reason, cravings, depression, and other issues may persist for years--perhaps forever--this (**Cont. p. 4**)

News Release:
ARM Announces New E-zine

February 15, 2005

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Advocates for Recovery through Medicine (ARM), the national organization representing medication assisted treatment patients, providers, family members and other interested parties, announces their new e-zine--**ARMED WITH FACTS**.

Since 2001, ARM had distributed a quarterly print version of **ARMED WITH FACTS**, but due to funding shortfalls, the print edition has been discontinued. However, the "new" **ARMED WITH FACTS** e-zine will be produced monthly, and will be able to reach a far larger audience.

To subscribe to **ARMED WITH FACTS**--email armawf@aol.com, with "subscribe" in the subject line.

ARM was started in 1998 as an educational organization for methadone patients. When the DATA 2000 Act legalized buprenorphine treatment in the USA, ARM expanded its mission to include this new medication assisted treatment patient population. Now, in 2005, with more and more addiction treating medications approved and in the pipeline, ARM has again expanded its mission to serve all medication assisted treatment patients, be they opiate users taking methadone, alcohol users taking naltrexone or cocaine users taking neurotin. If you or someone you know or love is taking medication to treat problematic drug use, check out ARM and **ARMED WITH FACTS**.

To learn more about medication assisted treatments, and to support our work, visit our website at <http://www.armmat.org>. ARM is a 501(c)3 non-profit organization.

Editor's Comments: As more effective medications have become available for the treatment of various drug addictions, it has become increasingly apparent that organizations like ARM are needed to educate those seeking addiction treatment, their families, and even providers of addiction treatment, regarding the usefulness of and need for medication-based addiction treatment.

Methadone patients are all too aware of the stigma against opiate agonist treatment. Negative attitudes regarding

methadone treatment are held not only by the general public, but also by providers of other "abstinence-based" addiction treatments and certainly by twelve step groups (i.e., Narcotics Anonymous).

While it appears that this anti-medication bias is not as bad with other medication-based treatments as it is with opiate agonist treatment (or at least in the case of methadone treatment), there is plenty of evidence that the mainstream addiction treatment community has a bias against medication-based treatments, such as those medications recently found to be effective in treating alcohol addiction.

It is a tragedy when an individual suffering from addiction struggles but is not directed to an effective medication-based treatment that may help. Oftentimes, they are not told about potentially effective medications because of the aforementioned bias against medication-based treatments; in other cases, the treatment provider (i.e., substance abuse counselor) fails to inform the individual about such treatments because s/he is unaware of the existence of these relatively new medication-based therapies.

Hopefully, ARM's new e-zine will reach those in need of addiction treatment, addiction treatment providers, and the general public, in order to educate them about the existence and value of various medication-based treatments.

Dear Melanie (from p. 3).

is simply the nature of opiate addiction. For whatever reason, whether the person was born that way or if the defect was caused by abuse of short-acting opiates, the endorphin receptor system is abnormal. Abuse of short-acting opiates (i.e., heroin) will further disrupt the brain chemistry, but methadone treatment does not. Methadone treatment is so effective at eliminating opiate cravings, because it corrects this chemical imbalance. Methadone serves as an effective opiate addiction treatment, but once patients withdraw from it, the relapse rate is high because methadone treatment is not a cure. To use the classic analogy--insulin effectively treats diabetes, but it is not a permanent cure, as it only keeps the disease in check as long as the patient continues to take insulin.

We hope that this at least answers some of your questions about withdrawing from methadone. Hopefully you will reach your goal of successfully withdrawing from methadone, but also remember that remaining on methadone maintenance does not make you or any other opiate addict a 'failure'. The purpose of treatment should be to remain functional and healthy without abusing drugs in an addictive manner. Eventual withdrawal from methadone may be a goal for many patients, but this is not the ultimate measure of success or failure.

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Methadone Today (Vol. X, No. III)

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DONT is a non-profit 501(c)3 organization dedicated to helping patients achieve quality methadone treatment, preserve patient dignity, provide greater public understanding, eliminate discrimination toward methadone patients, and promotion of harm reduction policies.

Won't you please help us cover costs of the newsletter, web site, etc. **Your donations are tax deductible.**

IT DOESN'T MATTER WHAT OTHERS DO--IT'S WHAT YOU DO THAT COUNTS. PLEASE, do your part--GIVE WHAT YOU CAN.

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