

# Methadone Today

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## Hurricane Katrina: Problems obtaining medication, among hardships faced

As we prepare this issue of Methadone Today to go to press, the disaster caused by Hurricane Katrina is unfolding. Among the many hardships being faced by residents of affected areas (New Orleans, LA, as well as other areas such as Biloxi, MS) are problems accessing needed medications--especially methadone. Because of the way methadone treatment is regulated, getting medicated in an emergency situation is more problematic for methadone patients.

In most cases, when prescribed for the treatment of opiate addiction, only small take-home supplies of methadone are dispensed. Perhaps an even bigger issue is that methadone treatment providers do not write prescriptions that can be filled at any pharmacy--they dispense the medication themselves. Obviously, this can become a major problem when methadone clinics are shut down--as in a major disaster, like a hurricane. Even those methadone patients that managed to evacuate to neighboring cities and states may have had issues getting dosed, as methadone clinics are not going to dose patients who normally attend another clinic without documentation from their clinic, verifying that the individual is indeed a methadone patient, and indicating the current dose the patient is on. The catch in an emergency is how does a patient get ahold of such documentation? Methadone clinics often do not have an emergency telephone number that patients can call if the clinic is closed?

Methadone clinics are supposed to be prepared in the event of such an emergency situation, but the reality appears to be that many clinics are simply not properly prepared to handle a serious emergency--never mind an emergency as serious as they have in New Orleans--or certainly, an emergency that occurs without warning, unlike a hurricane where there is usual advance warning as the hurricane approaches. Even assuming treatment providers have an emergency plan, how many methadone clinics have given their patients any kind of instructions on what to do in case of an emergency? If patients do not have emergency instructions, how would they know where to go or what **(Cont. p. 3)**

## Dear Methadone Today,

Greetings! I have been trying to obtain information from Health Canada but had no luck. I am hoping that you can help.

Presently, I have been on methadone maintenance for four weeks. The first four days, I did use opiates on a few occasions in addition to the 35 mg of methadone. Then it was increased to 45 mg and last week I had it reduced to 40 mg.

My aim is to reduce 5 mg every ten days until I am clean. I wish to know if this is a realistic goal?

I have been experiencing various side effects, and wish to know whether the twitching I am having that often increases to actual spasms is normal? At times it is severe and my muscles ache.

Prior to my drink in the morning, I feel chilled to the bone. Is this normal?

I have absolutely no appetite and therefore rely on a Boost as a supplement. Sometimes I use marijuana, which does give me an appetite. The THC also reduces my feelings of nausea, which I

## Dear Methadone Today,

I have been taking methadone for about 3.5 years at a methadone clinic in my town. I started on 40mgs/d and went up on my dose for years until I was comfortable on 220 mg/d. I have been weaning off of it for a couple of years.

I am now on 26 mg/d and comfortable on this dose for now. Recently I went on a one week vacation so I needed to get a week's worth of take-homes. So the day I went to pick up my take-homes, the nurse handed them to me and they were all messed up--there were 7 take-homes with **260 mg** in each one and I only take 26 mg/d. So she had to open all of them and measure all of them with a glass measuring tube. When I was on vacation, I lined up each take-home bottle and all of them looked off by many milligrams. I had to come home two days early from my vacation because I felt like I was withdrawing from heroin, I was unbelievably pissed off at my clinic. I wanted to call my lawyer and file a lawsuit because **260 mg** was a HUGE mistake and if I took that much I would be dead right now. These methadone clinics need to be careful and triple check all doses or they will get sued like I almost sued. **-Upset**

## Dear Upset,

Thank you for writing in. We're very sorry to hear your vacation was interrupted--that's no fun at all. If you had been taking 260 mg and the milligrams were off a bit, it wouldn't have been so noticeable, and you would not have had to return early. But when you are down to such a low dose, a few milligrams one way or the other is a very big deal. If it was off by only two to five milligrams, that's almost 10% - 20% of your dose respectively.

The most common liquid methadone formulation is concentrated at a rate of 10 mg per milliliter. In other words, assuming your clinic does not dilute the medication before dispensing it to you, [at 26 mg] your daily dose is only 2.6 ml of liquid. That means that the amount of liquid medication the dosing nurse is giving you must be measured very accurately. If your dose is off by just 0.5 ml, you would be getting 20% less **(Cont. p. 3)**

attribute to my Hepatitis C as well as the methadone. Would it be realistic to request pot pills or legal marijuana?

I also have great trouble sleeping. At times when I am exhausted, I take 5-10 mg Valium, and this does cause me to sleep. However, I understand this is a dangerous combination and therefore rely on pot to get some sleep. Is there an alternative that I could use for not sleeping?

I would appreciate your assistance in providing me with any information concerning adverse effects of taking methadone and thank you in advance for your help. **-Zoltan**

## Dear Zoltan,

No, your goal is not realistic. You should not even be thinking about withdrawing from methadone at this point. You aren't even stable yet, and you aren't at an optimal dose, as evidenced by your use of other drugs and medications and your statement that you are "chilled to the bone" in the morning before you **(Cont p. 3)**

## Research Trial Compares Outcomes of Rapid Detoxification with Other 'Detox' Methods

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

*Collins ED, Kleber HD, Whittington RA, Heitler NE. Anesthesia-Assisted vs Buprenorphine- or Clonidine-Assisted Heroin Detoxification and Naltrexone Induction - A Randomized Trial. JAMA (2005) 294:903-913.*

The current JAMA home page features this item with the caption: "Anesthesia-Assisted Heroin Detoxification: Collins and colleagues randomly assigned treatment-seeking heroin-dependent patients to anaesthesia-assisted rapid detoxification with naltrexone induction, buprenorphine-assisted rapid detoxification with naltrexone induction, or clonidine-assisted opioid detoxification with delayed naltrexone induction. They found that withdrawal severity, treatment completion and retention, and proportions of opioid-positive urine specimens during 12 weeks of outpatient treatment were comparable across the 3 methods of detoxification."

In fact, there are five items in this edition mentioning naltrexone, two being letters to the editor on a long acting injectable form for alcoholism. The current feature has a commentary by Patrick O'Connor on the role of detoxification. There is also a glowing historical tribute to Vincent P. Dole and colleagues whose seminal methadone report was published in this same summer holiday edition of JAMA 40 years ago.

With veteran researcher Herbert Kleber, this group from Columbia describe a randomised comparison of naltrexone induction in heroin addicts using three methods: (1) rapid detox under 4-6 hour anaesthetic (2) buprenorphine bolus and (3) clonidine with traditional in-patient detoxification.

The study raises several important ethical questions while also giving perhaps the last word on rapid detoxification from opioids, a century after the first report [MacLeod, N. Cure of morphine, chloral, and cocaine habits by sodium bromide. *BMJ* (1899) 15/4/1899 p896]. The main results are unremarkable: viz (a) that almost 100% of anaesthetised patients successfully take their first dose of naltrexone, (b) that rapid detox is hazardous, (c), that the naltrexone "treatment" is of very limited benefit (75-90% of subjects dropped out by 12 weeks) and (d) that the particular method of detoxification has no significant impact on rates of medium-term abstinence.

It is possible that some side effects in the anaesthesia group (n=35) may reflect this team's lack of experience as well as their limited ability to elicit a clear history from their patients. All three subjects who developed major anaesthetic complications are said to have had "concealed" histories (of diabetic ketoacidosis, bipolar disorder, pneumonia and sleep apnoea) from the researchers. To ascribe each anaesthetic complication to deceitful subjects is rather unusual and there may be alternative views. Others have reported lower complication rates, yet there is no doubt that such treatment can be hazardous in this population, especially if they come directly from street heroin habits.

Prescription of naltrexone for opioid addiction as a 'treatment' has only little limited scientific support in unselected candidates in community treatment. Some believe that it may have benefits in carefully selected subjects (as stated by O'Brien in the same issue p 888). So why did these authors go to so much trouble to 'induct' addicts into an ineffective treatment? I note that some providers now give very frank details about the expected success rates of their treatments. Yet others have claimed '100% success' rates and call their detoxification treatments 'painless'.

It is predictable that those taking pure buprenorphine were

retained for slightly longer than those given clonidine, which may be little more than a placebo in this situation. And it is self-evident that the anaesthesia patients were more likely to take their first dose of naltrexone which is given while they are still unconscious.

In his accompanying editorial Patrick O'Connor tells us that over 3 million Americans have used heroin and ten times that number prescribed opioids. Even more worrying is that over 1% of school children in the US had used heroin in 2004. Thus we are dealing with an epidemic in anyone's terms.

As with McGregor and Ali's randomised study from Adelaide (D&A Rev) rapid detox shows no significant benefits over traditional detoxification in the medium term (3, 6 or 12 months). In view of the high risks and poor results, there should probably be no further studies of rapid detoxification in unselected subjects. It is still possible that longer acting forms of naltrexone may yet prove effective for those seeking abstinence. Formal research on the safety and effectiveness of such novel delivery methods is awaited.

**Editor's Note:** Beyond the finding that rapid detoxification or UROD (Ultra Rapid Opiate Detoxification) does not have a better success rate than certain other withdrawal methods, the results of this trial are notable to the extent that they reveal how dismal the success rates are for all of these withdrawal methods. As Dr. Byrne suggests, clonidine--by itself--is often woefully inadequate at easing withdrawal symptoms. Clonidine may be helpful in conjunction with other medications. As we have discussed in previous issues, buprenorphine is a useful medication but is not very helpful when used on such a short term basis.

This trial appears to confirm that the opiate withdrawal method with the highest probability of success is a gradual taper using either methadone or buprenorphine. Still, long-term or indefinite maintenance on opiate agonist treatment (e.g., methadone or buprenorphine maintenance therapy) may be the best bet for many opiate addicts, given the high relapse rate following withdrawal--even when utilizing the best opiate withdrawal methods.

### 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, IL, Downers Grove, IL & Westbrook, Maine;
- 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.

**Hurricane Katrina (from p. 1).**

to do should an emergency arise? During the last major power outage, many patients discovered that their methadone clinics, assuming they were open, did not even answer the phones. The phone systems at many methadone clinics will not work if there is no power. If the September 11, 2001 terrorist attacks and the last major power outage did not serve as a wake-up call for methadone treatment providers and State Methadone Authorities (agencies that regulate methadone treatment at the state level), perhaps Hurricane Katrina will.

As far as government regulators and accreditors are concerned, it is unacceptable to simply leave it to treatment providers to come up with their own emergency plans. This is precisely the sort of issue that accreditors should be addressing. Accreditors should have comprehensive guidelines that methadone treatment providers must follow to obtain accreditation.

Fortunately, it is our understanding that at least in Louisiana (LA), the State Methadone Authority (SMA) is doing its best to care for the methadone patients who were displaced by the hurricane. The SMA said they have been working really hard to make sure patients are being taken care of. The pharmaceutical companies have donated methadone for over 200 patients. They will be setting up a spot at the Baton Rouge Hospital for dosing and the SMA will

issue a press release regarding this. There is such a mess there now, it will take awhile before it will be all sorted out.

ARM/DON'T has set up an account so that people who wish to donate can. The fund will be for patients to help pay for their treatment. Check out the ARM web site ([www.armmat.org](http://www.armmat.org)) or go to [www.methadonetoday.org](http://www.methadonetoday.org) and click on the ARM link if you wish to donate to the Katrina Fund for Methadone Patients.

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

[or more] than you should be. Obviously, if a dosing nurse is manually measuring doses, s/he would have to use an instrument that is accurate and readable to 0.1 ml. If a liquid formulation of methadone is to be used, there is certainly something to be said about computerized dispensing, although even then there are potential issues.

We definitely suggest that patients at least glance at their dose before ingesting it. Likewise, with take-homes, these should be given a quick check before leaving the clinic. Patients may help catch a major mistake just by being aware.

It was a huge mistake to give you 260 mg when you should have been given 26 mg. Thank goodness the error was caught. Fortunately, dosing errors are rare, and they are usually caught prior to ingestion of the medication by either the nurse or the patient.

Nevertheless, we still think that it would be better and safer to dispense methadone in solid, rather than liquid, form. The new federal regulations do not require that methadone be dispensed in liquid form. Even if state regulations or clinic rules mandate that methadone doses be dispensed as liquid, methadone wafers or diskettes that are mixed with water or juice before being dispensed to patients could be used. That way, patients could observe to see that the correct amount of wafers or diskettes are in their doses.

Please send articles, letters, etc. for publication. We want your input whether you are a patient or clinic staff.

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

take your methadone.

We really can't comment on your question about requesting marijuana. Whether or not it would be a good insomnia treatment in your situation, it is very unlikely that you could get a prescription for marijuana or "pot pills", by which we think you mean THC pills. However, we can tell you that benzodiazepines, such as Valium, are potentially dangerous when taken in conjunction with methadone, especially if you are not taking it under the advice and supervision of a physician who is aware that you are on methadone for opiate addiction treatment and aware of any other medications you are taking. Besides, benzodiazepines are generally only suitable for the treatment of insomnia on a short-term or episodic basis. You need to increase your dose of methadone, which should take care of the problem you are having with not being able to sleep. The twitching and spasms you are experiencing are not side effects of methadone. In fact, methadone has been studied more than any other medication over the past several decades, and there are very few side effects. The most common are constipation, sweating and reduced libido. The twitching and spasms might actually be withdrawal symptoms, as you are not at a sufficient methadone dose to suppress opiate withdrawal.

Our advice is to get your dose of methadone increased gradually (80-120 mg is the range most patients need for effectiveness), and don't worry about withdrawing. You are not ready, and maybe you never will be. Many patients will take methadone for life. Most patients (upwards of 90%) who withdraw from methadone return to daily opiate use within a very short time. Even under optimal conditions, with no stressors in the patient's life, about 80% relapse. Of those who do not relapse to opiate use, many substitute other drugs, including alcohol. With Hepatitis C, alcohol is absolutely contraindicated. In contrast, methadone is not destructive to the liver. Note that remaining on methadone a longer period of time does not decrease the probability of successfully withdrawing off methadone if you attempt to do so. In fact, patients who stay on maintenance treatment longer are more likely to successfully withdraw from methadone without subsequent relapse.

We do not make anything off of methadone. Our interest in patients staying on this life saving medication is that it works, and most of those who quit taking it relapse. As Dr. Dole who, along with Dr. Marie Nyswander, conducted the pioneering methadone maintenance research, and is considered the 'Father of methadone maintenance treatment', said in an interview for *Methadone Today*, "The goal is not abstinence; the goal is to become functional. The data collected over the years has shown that abstinence is an unlikely goal. It is a terrible mistake to put someone in the position of either eventually becoming abstinent or becoming a failure." We hope this helps.

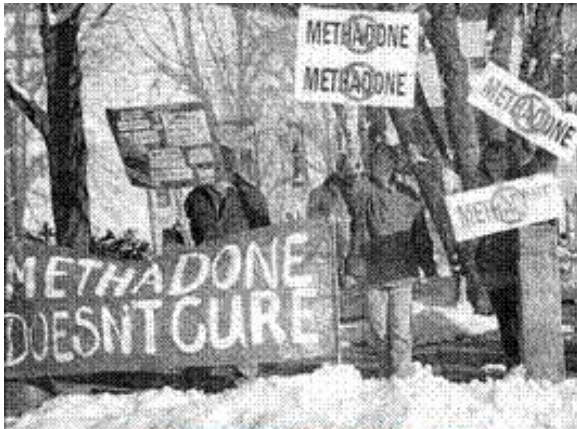
**NIMBY (from p. 4).**

educate community groups. It is available for download free of charge at: [http://www.atforum.com/SiteRoot/pages/addiction\\_resources/com\\_ctr\\_d\\_mmt.pdf](http://www.atforum.com/SiteRoot/pages/addiction_resources/com_ctr_d_mmt.pdf)

**Editor's Note:** Ironically, by fighting to keep methadone clinics out of their neighborhoods, community activists are arguably making their communities less safe. If methadone treatment providers cannot find places to open methadone clinics, methadone treatment will remain inaccessible to those who need it. Opiate addicts in methadone treatment are statistically far less likely to commit various crimes (i.e., buying and selling drugs, theft, etc.). When will people realize that accessible methadone clinics benefit not only opiate addicts, but everyone else as well?

## NIMBY: Remarkable Controversy, Still Going Strong

Reprinted from *Addiction Treatment Forum*, Volume 14, #3  
(Summer 2005). Also see <http://www.atforum.com>.



Citizens protest an MMT clinic in Maine.  
Photo, R. O'Malley, *Courier-Gazette*, 12/7/04.

Almost since its beginning in the mid-1960s, methadone maintenance treatment (MMT) has been plagued by NIMBY; mostly, due to the stigma, prejudice, and misunderstanding surrounding this very effective therapy for opioid addiction. An acronym for "Not In My Backyard," NIMBY universally applies to resisting any unwanted development--e.g., prisons, chemical plants, landfills--from entering a community.

Everyone it seems wants their community roads lined with parks, trees, quaint schoolhouses, and upscale boutiques. In contrast, opponents of MMT clinics have characterized them in press reports as dingy eyesores that serve loitering "junkies" with needles hanging out of their arms as drug pushers prowl nearby. In reality, the clinics serve those opponents' neighbors, family, and friends who may develop opioid dependencies for numerous reasons.

As one Homeowner Association president put it: "We're all in favor of treatment programs, but not in this neighborhood" (*Bristol Herald Courier* [VA], 12/13/03). Or, as a police chief stated: "It's like a nuclear power plant. People need it, but they don't want it in their back yard" (*Portsmouth Herald* [NH], 5/7/05). Messages

like those have been repeated in various ways time and again through the years, and in communities throughout America.

Where should MMT clinics be located? The answers often include, "...away from our schools, away from our children and parks... and residential and business areas" (*Roanoke Tribune* [VA], 2/26/04). Sometimes, local hospitals have been suggested as logical outposts for MMT clinics; however, due to persistent stigma and prejudice, hospitals rarely want anything to do with methadone treatment for addiction.

One solution has been putting MMT on wheels via methadone-dispensing vans, as in Vermont (see, *AT Forum*, Summer 2004). Even then, many months passed as one community after another debated suitable sites where the van could stop briefly each day to serve patients (*Times Argus* [VT], 3/29/05, 6/17/05).

Increasing numbers of methadone-associated deaths in recent years have inflamed community fears. Yet, according to all reports, including a federal government investigation, MMT clinics are not the source of "killer methadone," as news media have described it (see, *AT Forum*, Spring 2004). And, contrary to protests by community activists, police authorities have often insisted there is virtually no increase in vehicle traffic or crime associated with local MMT clinics (*Washington County News* [VA], 12/25/03).

Good news about MMT often goes unreported. An exception was the headline, "Feared problems fail to materialize at clinic" (*The Herald* [WA], 1/31/05). Following a 7-year battle to open an MMT program in Everett, Washington, nearby residents, police, and city leaders reported the clinic had been a "good neighbor" without any signs of problems. This sort of success is much more common than many realize or the press reports.

Yet, as one editorialist observed, the fact that MMT is still surrounded by debate and controversy after nearly 40 years is remarkable (*Bangor Daily News* [ME], 11/27/04). No matter where a clinic is proposed, opposing arguments generally founded on ignorance have continued much the same through the years. The unasked and unanswered question is: Why doesn't the public know the truth about MMT and its demonstrated benefits to individuals and their communities?

AT Forum has prepared an 8-page report titled, "A Community-Centered Solution for Opioid Addiction: Methadone Maintenance Treatment (MMT)." This document provides an evidence-based and balanced perspective on the treatment of opioid addiction with methadone that can be used to **(Cont. p. 3)**

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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.

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