

Methadone Today

The official newsletter of DONT--by patients, for patients November 2005 Volume X Number VIII

HBO Airs Negative, Misleading Documentary About Methadone Patients

Concerns have been raised by methadone patient advocates and methadone treatment physicians about a documentary aired in October on HBO called "Methadonia". This "documentary" presents methadone treatment in a very negative light--misleading viewers about methadone treatment and methadone patients. The film focuses on the very small percentage of methadone patients that fit the preconceived notion of methadone as perpetuating, rather than treating, drug addiction. In particular, the methadone patients in the film abuse benzodiazepines--a class of prescription drugs which include Xanax and Valium. These medications have sedative/tranquilizing/hypnotic effects and are prescribed for the treatment of anxiety disorders, as well as (usually on a short term basis) for insomnia and alcohol withdrawal. Benzodiazepines slow the metabolism of methadone, resulting in greater intoxication than if benzodiazepines were taken alone. Note that methadone clinics are well aware of this and routinely test for benzodiazepines.

However well-intentioned Michel Negroponte, the director of the film, was when he made "Methadonia", he did methadone patients and opiate addicts a great disservice by perpetuating the methadone stereotype. There is already stigma associated with methadone treatment. The last thing methadone patients need is another negative story about methadone treatment that erroneously stereotypes methadone patients as dysfunctional people who continue to abuse drugs. Any mention of the good that methadone maintenance has done was lost in the parade of patients who were abusing other drugs. This documentary was made without consulting advocates who would have pointed out to Mr. Negroponte that he was doing irreparable damage to patients whose lives have been saved by this medication. Instead, he chose to hand pick those who fit into the stereotype about methadone treatment and methadone patients.

Aside from the issue of how representative the patients profiled in the documentary are of methadone patients generally, there is the question of whether these patients are **(Cont. p. 3)**

Dear Methadone Today,

My 26 year old son died last year of a methadone/Xanax overdose. He had been home from inpatient rehab for only two days after a 28-day detox and was currently not on methadone, but the autopsy report showed methadone in his system. His detox was traumatic; he was very ill physically, lost a lot of weight and the stress on his body was visible. But he was beginning to feel better approximately 2 - 3 days before being discharged. He was given a prescription for Xanax upon his discharge, even though he was being detoxed for benzodiazepines as well. He did not leave the house, nor did anyone visit him once he was home. He had a positive attitude about finally being detoxed from methadone--he felt he had a new life waiting for him and was so relieved to be home, he glowed. My question is, how long does methadone stay in the system? Or could this have been a psychological side effect? It's so incredible, that after a 28-day rehab, the methadone would show up in the autopsy results. If it is true that methadone stays in the system for a prolonged period of time, WHY would a benzodiazepine be prescribed upon discharge, and why would he be discharged so soon? ESPECIALLY with a long history of depression, manic behaviour, and numerous suicide attempts!

I'd also like to comment, HBO's new documentary--Methadonia--really hit home with me. I am a recovering addict and have been free from methadone for 22 months. It was a very tough detox, but I somehow managed to get through it. This documentary zeroed in on the use of benzodiazepines with methadone and the underlying problems faced by the recovering addict. I never personally used benzodiazepines with the methadone and was prescribed clonidine and Ambien to help me through the withdrawal symptoms on an outpatient basis, but I suffered for over 3 1/2 weeks after stopping at 10 mg of methadone--insomnia, anxiety, severe diarrhea. I was able to tough it out at home with the help and support of family, but I feel the withdrawal would have been easier as an inpatient. Since the loss of my son last year, I have been struggling with the thought of using heroin again. But after seeing this documentary, watching these people exist being robots to methadone, and the many, many unsuccessful attempts **(Ct. p. 4)**

Dear Methadone Today,

I've been at a methadone clinic for five years, and I've been at 150 mg/d the whole time. I've been detoxing for months by 2 mg a week--which is the way they want you to do it, but I'm afraid of getting sick when I'm done. I'm at 29 mg/d now. I'm scared I'll get sick and just be back down there or using again.

The clinic I attend has about 4000 patients. There is no waiting list, and they don't ever talk to anyone about getting off the shit. There are seven windows, and it's \$12.00 a day. It's all about money. My two best friends got kicked out at 150 mg/d, and they were detoxed in ten days because they couldn't keep up with paying their money. And now they are smoking crack! I have to get up at 3:00 am to get a number in the parking lot to be out by 5:00 am to get home and get ready for work--I'm so sick of it!

My question is how long will it take to get all the methadone out of my system? And when will I feel better?

Dear Nicole,

Not to defend a methadone clinic that we know very little about, but pressuring patients to taper off of methadone is not what methadone clinics should be doing. Your methadone clinic may be a bad clinic and may only care about money. If they are a bad clinic, it isn't because they do not suggest that patients taper off of methadone. The relapse rate for patients who withdraw from their methadone dose is high (80-90%). The only patients who have a realistic chance of completely tapering off of methadone without relapsing are those who are not only stable and not using illicit drugs but are also determined to withdraw from methadone; that is, they are doing it for their own reasons rather than because of outside pressure. Patients who only attempt a methadone taper when their clinic counselor or physician push them are very likely to fail. Remember, the consequences of a relapse may be very serious--as you should know from seeing what happened to your friends who were withdrawn from **(Cont p. 3)**

Dear Methadone Today (from p. 1).

their methadone doses due to inability to pay for treatment, and are now abusing crack. Granted, withdrawing a methadone patient on 150 mg/d in ten days is NOT a therapeutic taper; relapse is almost certain at such a rapid rate.

Nor does the size of a methadone clinic indicate whether the treatment being provided is of good quality or not. However, we do think that some methadone clinics could do a better job as far as how long patients have to wait to be medicated. While early morning is typically the busiest time for methadone clinics, two hours seems like an excessive wait. We are assuming that the two hours you state you are spending at the clinic is on days that you are not having a counseling session. You do not state how often you have to attend the clinic, but after being at a methadone clinic for five years, you should probably only be attending once a week, or less frequently, depending on the state regulations and clinic policy; that is, assuming that up until now, you have been stable and illicit drug free. We would like to see more states change their regulations to match the federal regulations, at least when it comes to take-home medication and clinic attendance. Long term, stable patients should only need to attend their methadone clinic once or twice a month unless there is some compelling reason why the patient should not be trusted with a larger take-home supply.

If anything, there should be regulation on patient-to-staff ratios rather than the number of patients. In other words, how many patients does each counselor have. Similarly, if the wait to be dosed is too long, the methadone clinic should have more dosing nurses, at least at certain times of the day. Other than that, size of a methadone clinic does not necessarily mean anything; there are bad clinics that are small and only serve a relatively small number of patients, and good clinics that are large.

Furthermore, the fact that there is no waiting list is a good thing. Waiting lists mean that there are opiate addicts in need of treatment who are not getting it. Also, poor quality treatment is more likely to be an issue in areas where there are waiting lists... methadone clinics that have waiting lists certainly have no economic incentive to treat patients well; they have people waiting to replace patients that get disgruntled and drop out or transfer to another methadone clinic [assuming there is another clinic that they can transfer to that doesn't have a waiting list as well].

Now on to your concerns about withdrawing from methadone. Most likely, you will experience some discomfort--especially insomnia for a period of time, especially when you reach the end of your taper and a matter of weeks after you ingest your last methadone dose, though how long varies from individual to individual. If by "sick" you mean full blown withdrawal symptoms, like what you experience when you quit heroin 'cold turkey', you should not worry too much. However, you may feel a little 'off' and have trouble sleeping for awhile. Such symptoms will eventually recede, but opiate addiction may be physiological in nature. In many opiate addicts, the physiological/chemical imbalance may be permanent. It is possible that you may never feel completely 'normal' without being on methadone treatment or otherwise abusing illicit opiates. Methadone treatment corrects the imbalance as long as you continue on your maintenance dose, but like insulin in diabetics, it does not cure the problem.

We are not saying that you WILL have a problem, but if you do, you would be much better off getting back on methadone treatment than relapsing to illicit opiates. Unfortunately, the relapse rate following withdrawal off of methadone is high. This is not a shortcoming of methadone treatment but simply the nature of opiate addiction.

A lot of methadone patients' complaints seem to be related to the methadone clinic system rather than methadone treatment itself. I gather that you would not be as eager to withdraw from

methadone if you could attend a methadone clinic, or better yet, a doctor's office and get a month's supply of medication at a time for a more reasonable price. Some states already permit these kind of "extended take-home supplies" for patients who would be eligible for them under the federal regulations. Methadone patients in states with stricter regulations should contact their state representatives and ask them to consider reforming the state regulations to allow long-term, stable methadone patients, who have demonstrated that they can be trusted with medication, to obtain a monthly supply of medication like any other patient receiving a medication for a long-term medical condition.

If you do not ultimately succeed in withdrawing from methadone, you may want to consider switching to buprenorphine. If you can stabilize on a low dose of methadone, you may be a good candidate for buprenorphine maintenance treatment. Buprenorphine patients are able to go to a doctor's office and be prescribed a month's supply of medication at a time--even newer patients--with few of the rules and restrictions that methadone patients are subject to. However, we should warn you that buprenorphine treatment is likely to be more expensive than methadone treatment. The medication itself is expensive because there is still a patent on it (i.e., there is no generic version of the medication available).

Dear Doctor,

I am a methadone patient who has been on 47 mg/d and stable for several years now. Recently, when I was in the hospital following major surgery, they put me on a morphine pump for the first couple of days. The doctor told me that he could not give me my methadone while I was on the pump. Once I was taken off the pump, they started giving me my usual 47 mg/d.

Was this doctor correct that a maintenance dose of methadone should not be given to a patient while on a morphine pump? I was concerned that my methadone clinic wouldn't dose me if they saw I wasn't getting my dose while in the hospital. **-LM**

Dear LM,

We [the Editors] sent your question to Dr. Marc Shinderman, who in turn contacted a couple of colleagues with expertise in pain management issues. The consensus was that not only was it okay to continue providing a patient his maintenance dose of methadone while on a morphine pump, but that it is the recommended course of action.

As one of Dr. Shinderman's colleague's indicated, withholding a stabilized methadone patient's maintenance dose while on a morphine pump, complicates matters. Predicting how much extra morphine will be needed to make up for the opioid "deficit" resulting from a failure to provide the patient's maintenance dose of methadone is not easy. In the worst case scenario, the patient could even develop withdrawal symptoms.

Finally, you are correct that your methadone clinic could give you a hard time if you were not dosed for a significant period in the hospital. They would probably not refuse to dose you entirely, but they may drop you down to 30 mg/d. The concern is that if you missed more than a few days of methadone doses, your tolerance may have dropped; that is, you could possibly overdose if given your usual dose. Chances are this would not be an issue. As long as they put you back on your maintenance dose of methadone for at least a 2-3 days before releasing you, the methadone clinic is unlikely to give you trouble. Still, if there is an issue, it is you and not the hospital doctor that stands to suffer.

The COVER Story

Documentary (from p. 1).

receiving quality treatment. If Mr. Negrofonte had done his homework, he might have discovered that the sort of failures in treatment he highlights are often the result of improper dosage. In a recent New York Times article*, one patient profiled in the film is quoted as saying, "[we] hang by our knuckles every day to stay clean," and, "[a]n ex-junkie never forgets that high." One cannot rely simply on what a patient says to determine whether s/he is properly dosed, but this does sound like a methadone patient who may be underdosed. If Mr. Negrofonte really wanted to help such patients, maybe he should have discussed how proper dosage makes all the difference between success and failure in methadone treatment.

The sort of treatment failures outlined in "Methadonia" may also result when the patient is not receiving the type of quality counseling s/he requires, or the patient is not being properly treated for mental illness secondary to their addiction. Some addicts suffer from a pre-existing mental illness and used illicit drugs to 'self-medicate' it. Depending upon the nature and severity, a methadone patient who is not treated for mental illness may continue to self-medicate with illicit or prescription drugs (i.e., benzodiazepines).

Finally, some of the patients abusing benzodiazepines get their psychiatrists or general practitioners to prescribe such medications by withholding information--not telling their doctors about their addiction history or that they are on methadone treatment. Although there are limited circumstances where doctors may prescribe benzodiazepines long term to a methadone patient, they are generally very reluctant to prescribe such medications to patients with an addiction history--especially in the case of a patient on methadone treatment, as benzodiazepines interact with methadone. Assuming the methadone patient is truly interested in overcoming drug addiction, s/he has a responsibility to be honest with doctors.

All this leads to another disturbing aspect of this film. This film reveals a double standard when it comes to methadone treatment vs. other non-

medication based drug addiction treatment. Methadone maintenance treatment is the Rolls Royce of opiate addiction treatments. In terms of success rate and functionality, there is no treatment that even comes close to opiate agonist therapy (e.g., methadone or buprenorphine maintenance treatment). Yet, the media rushes to blame methadone treatment for any patient who does not completely abstain from illicit drugs. When it comes to abstinence-based therapies for drug addiction, the media is far more forgiving.

Success rates should be examined to determine the effectiveness of a given treatment. However, a 100% success rate is not a realistic expectation in the treatment of ANY disease or medical condition. Even if a treatment were properly administered--in the case of methadone treatment, with optimal dosing and quality counseling, as needed, as well as proper treatment for any mental illness that the patient may have--there are going to be at least a small percentage of patients who don't do well in treatment.

"Methadonia" is just another disappointing example of methadone-bashing in the media. It is time that a documentary was made about all the stable methadone patients who live normal, functional lives with little fanfare. Granted, it would take a film maker more effort to find successful methadone patients willing to be on camera. Because of the stigma associated with methadone treatment (and because of documentaries such as Methadonia), most functional patients would rather that friends, co-workers, and employers not know that they are on methadone. But a few brave methadone patients would be willing to come forward to show people how methadone treatment allows opiate addicts to live a functional, productive life. In the meantime, it would be nice if the news media would set the record straight about methadone treatment and its benefits to countless patients .



Dear Jan H. (from p. 4).

the fortunate minority of opiate addicts that is able to function well without opiate agonist therapy, but if you have to resume methadone treatment, do not feel bad.

You also asked how long methadone stays in one's system. While methadone or its metabolites is detectable

by urinalysis for several days, for purposes of an autopsy, the medical examiner is interested in whether a substance was taken recently enough to have contributed to the person's death. Stephen would have had to have taken methadone within 24-36 hours to have any effect whatsoever. If the autopsy report indicated that methadone was a contributing factor to his death, he must have taken methadone after he came home. Maybe he had some methadone stashed away beforehand that he decided to use in combination with the Xanax.

What he and many other opiate addicts and methadone patients often do not realize is that following withdrawal, 'cold turkey' or otherwise, tolerance can rapidly decrease. In other words, if he used the dose of methadone he was on prior to withdrawing from methadone in combination with Xanax or another benzodiazepine, he could fatally overdose.

Finally, you mention "Methadonia", the supposed 'documentary' aired on HBO. For a full critique of this film, see the article on page 1, "HBO Airs Negative, Misleading Documentary About Methadone Patients," but we will briefly respond to you here.

People should know not to believe everything they view--especially when it comes to methadone treatment. The film maker apparently picked out the most dysfunctional methadone patients he could find. Abuse of benzodiazepines and other drugs is rare in methadone patients stabilized on an adequate dose.

You state that, "the heroin addict can never be free of the memory of that first 'rush', and will go to any lengths to experience it again." An adequate methadone dose should quell such drug cravings. Any methadone patient that will "go to any lengths to experience [a 'rush']," is likely improperly dosed. A stable methadone maintenance patient should not be spending their waking moments resisting a continuing urge to get high.

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Dear Methadone Today (from p. 1).

of trying to detox from the drug, I feel I will never, ever use drugs again. Losing my only child to the disease of addiction has been an unspeakable hell for me. If he had been able to go into LONG TERM INPATIENT TREATMENT, he possibly would have been a success story. But the fact is, the heroin addict can never be free of the memory of that first "rush", and will go to any lengths to experience it again. On the other hand, when buying heroin has become impossible, when all the money resources are gone and all the fronting from dealers has been used up, our only option is methadone. Once in a program, it is TOO EASY to obtain prescription benzos to get us high once again, if even for a short time before we build up the tolerance to these "legal" pills. If I were to obtain heroin at this point, it would only be to commit suicide--and I am a devout Catholic.

If Stephen had not been released so soon, and if he had not been given Xanax upon his discharge, he might be sitting here next to me. Instead, I have to drive to the cemetery, and kneel before his tiny headstone.... **-Jan H.**

Dear Jan H.,

We are very sorry to hear about the loss of your son, Stephen. Losing a child, regardless of the circumstances, is a tragedy. We will try to provide you some information and insight into your son's death, but we doubt it will give you any comfort. Perhaps your story can help others avoid the same tragedy.

We feel that there were many mistakes made in your son's case, based on the information you provide. Note that we are not physicians and are not offering specific medical advice. Stephen suffered from mental illness--clinical depression and depending on what you mean by "manic behaviour", maybe bipolar disorder. These issues were severe enough that he had attempted suicide numerous times. Moreover, you state that during this "inpatient rehab" he was also being withdrawn from benzodiazepines. We do not know, given what you have stated, whether Stephen was abusing benzodiazepines or if he became physically dependent on them by using them under medical supervision, but in either case, this has serious implications. Given these factors, we feel that withdrawing someone from methadone in a period of 28 days is totally inappropriate and irresponsible.

Add to this the fact that Stephen was being simultaneously withdrawn from benzodiazepines. In our opinion, attempting to withdraw someone from both methadone and benzodiazepines in

a 28 day period is inhumane and risky, especially someone who has the type of mental health issues that Stephen did. A safer and more humane approach would have been to withdraw him from just the benzodiazepines. If he should have ever been withdrawn from methadone, it should have been done well after he was withdrawn from benzodiazepines. Besides, a gradual taper from methadone is generally the best method as far as success rate and withdrawal symptom severity.

Understand that had Stephen survived, the odds that he would have abstained from illicit drugs and/or alcohol long term are extremely low. A good candidate for withdrawing from methadone is stable; that is, they are stabilized on an adequate methadone dose and are not abusing drugs, including alcohol and other non-opiate drugs, such as benzodiazepines. Even for the best candidates using a gradual methadone taper, the percentage that will relapse at some point following withdrawing from methadone is high (about 80%). Thus, we feel that Stephen would have likely been better served had he been withdrawn from benzodiazepines only and then possibly later very gradually tapered from methadone probably on an outpatient basis.

We also believe that this case reveals a mentality that is potentially dangerous and certainly reflects a misunderstanding of opiate addiction and opiate agonist therapy (i.e., methadone and buprenorphine treatment). The ultimate goal in treatment should not be withdrawal from methadone at all costs. Too many methadone clinic staff believe that treatment is not successful unless/until the patient is completely withdrawn from methadone.

The fact is that for many methadone patients, lifelong maintenance treatment may be the best option. Opiate addiction appears to be rooted in physiology--a chemical imbalance in the brain. Though this chemical imbalance sometimes corrects itself over time, in many opiate addicts, it may be permanent. Many experts liken methadone maintenance treatment to insulin therapy in diabetics--a highly effective treatment that corrects the aforementioned chemical imbalance but is not a cure. That is, like with insulin therapy, methadone allows opiate addicts to live a normal, functional life without craving or using illicit drugs but only as long as they remain in methadone treatment. Some may be able to withdraw from methadone, feel normal, and live a functional life without relapsing to illicit opiate use or resuming methadone treatment, but many opiate addicts may never be able to feel and function normally without opioids. There is no shame in this. Methadone maintenance treatment IS a medical treatment, a highly effective medical treatment. Maybe you will be one of **(Cont. p. 3)**

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Methadone Today (Vol. X, No. VIII)

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