

Methadone Today

The official newsletter of DON'T--by patients, for patients March 2006 Volume XI Number II

The High Profit of Doing the Right Thing

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The Johnson Institute (www.johnsoninstitute.org)

Helping people get well from alcohol and other drug addiction makes good sense. It also makes good "cents." Recovery is a bargain for society. When fully available to everyone afflicted or affected by addiction disease, millions of dollars will be saved.

Individuals and families who have survived addiction are not surprised that recovery saves money. Their experience is documented by research—most studies showing that every dollar spent on treatment saves from seven to twelve dollars in health care, social and criminal justice costs.

It is a shock, however, to see a government pay for treatment and recovery support—expecting a return by saving money on primary health care.

The State of Washington just made this landmark decision: to fund everyone eligible for Medicaid for addiction treatment *when diagnosed*. They boosted their treatment budget to \$39 million for each of the next three years—\$32 million for adults and \$7 million for youth. They expect \$31 million return each year in reduced claims for other health issues. If this savings happens, they will keep on paying for treatment when diagnosed after 2007.

Their official "Treatment Philosophy", posted on their website (www.dshs.wa.gov/dasa/services/treatment/treatmentphilosophy.shtml), should be placed over the door of every managed care office in the United States. In part, it says:

"Research demonstrates that treatment results in a marked reduction in negative consequences for the addicts, their families, friends, and society at large, as measured by domestic violence, disrupted families, employment histories, and public costs for law enforcement and the courts, welfare dependence, medical and hospital costs, and admissions to psychiatric hospitals."

Because they expect real savings, the treatment and support offered is not stingy. Up to six months of care (**Cont. p. 3**)

Dear Methadone Today,

I'm going to ask you my question before I get into my story. I understand you may be pressed for time and figured you'd rather hear the issue I am asking your advice on before the "tale of woe" that has fueled my passion on this issue.

WHAT can I DO to affect realistic changes in the current policies of the "incarceration industry" in the U.S. toward continuation of medication for incarcerated methadone patients? The experiences I describe below seem to be the rule, not the exception. I want to get involved . . . but what can I do that will have an impact?

I have been on MMT since August 1999. During my close to 7 years on methadone, I've attended a clinic in Asbury Park, NJ. I work closely with the Central NJ affiliate of ARM, "NJAdvocates" (www.njadvocates.org).

In my 7 years on MMT, I had one relapse, from 11/2001-12/2003. I've been 100%--no slips, 7 meetings a week, step working, sponsored and sponsoring, coffee and speaking commitments, etc.--clean and sober since then, recently celebrated two years, and have been carrying 6 takehomes (again!) for almost a year. The reason I give you this history is to help you understand that while I personally am doing well, my "personal stock" has gone down in the eyes of my clinic's hierarchy. When I was a "poster child" for MMT during my first few years on MMT, I had walk-in access to our clinic's executive director, the respect of all the "powers that be," etc. After my relapse, after all the lies and dope fiending that went along with it, I betrayed that trust and doubt I will ever regain it. In other words, my words were once taken seriously and given "weight," whereas now what I may bring to the attention of clinic staff is considered to be just the ramblings of another junkie.

One of the most memorable. . .and painful. . . experiences I had during my two years of relapse hell, was learning first hand about the policy of penal institutions toward MMT patients. Most of my "time" was in a county jail, MCCI in Monmouth Cty., NJ. There, only pregnant women, whether on MMT or simply addicted to street narcotics, are given methadone, up to the birth of their baby, at which point they are cut off cold turkey. MMT patients who are not pregnant, no matter what type of charges they're in for (**Cont. p. 3**)

Dear Methadone Today,

I never thought I would be writing this letter. I am a methadone patient and take a 420 mg/day split dose. I am also a totally disabled veteran and receive all my medical care from the VA. I awoke one morning in October 2004, just not feeling right. The night's sleep just wasn't normal, but I could not put my finger on the problem. I took a cab to the VA hospital, and they said, "Go home and take a couple of aspirin and you will be fine."

A friend of mine, who is a cab driver, picked me up and asked me what they said. I told him.

Well, I never made it home. In the cab, I passed out. My friend pulled over and saw I wasn't breathing and began to give me CPR. He called his dispatcher, who in turn called 911.

They took me to the nearest hospital, which wasn't the VA. At first, they thought it was an overdose, but the EMT was quick to give them the Medic Alert Card they found in my wallet. At this

point, they intubated me and started with the tests. To make a long story short, I had Methicillin-resistant staphylococcus aureus (MRSA).

They kept me in a drug-induced coma so that they could keep me intubated. After five days, I started to go into withdrawal. My sister and a close friend strongly insisted that I be given my methadone. The only problem was that they refused to give me my normal 420 mg dose and agreed to 210 into my i.v. line in divided doses. By the second day, I sat up, pulled the intubation tube out and in strong language demanded to know where I was, what in hell was going on, and bring me some damn food. After about another week in a nursing home to continue my i.v. therapy, things were back to normal.

You can bet dollars to donuts that had I not had that Medical Alert Card, they would have given me Narcan, and I would be looking into the eyes of the devil himself. Up close and personal. Don't leave home without it. -Mike (**Cont. p. 4**)

Norwegian comparison of methadone and buprenorphine

by Dr. Andrew Byrne, Dependency Medicine
(New South Wales, Australia)

A randomised clinical trial of methadone vs. buprenorphine to opioid dependants. Kristensen O, Espegren O, Asland R, Jakobsen E, Lie O, Seiler S. Tidsskr Nor Laegeforen 2005 125;2:148-151

After decades of denial in Norway, methadone was finally introduced in 1998 and buprenorphine in 2000 for opioid dependence. These researchers set out to compare the effects of the two maintenance therapies in their own drug using population.

There were 50 long term (>10 years) opioid dependent subjects randomised to receive 16 mg fixed dose buprenorphine or variable dose methadone (mean daily dose 106 mg, range 80-160 mg) over 6 months observation. Patient retention rate was 85% in the methadone group and 36% for those prescribed buprenorphine. Opiate positive urine tests were slightly lower in the methadone group (20% vs. 24%). Importantly, the methadone subjects reported less high risk behaviour. For some reason, only the buprenorphine group (or the minority who remained in the trial) reported significant improvements in general health.

This small study should be the last to compare methadone and buprenorphine in this way. Their results were predictable, adding little more than Scandinavian corroboration to 20 years of preceding research. The fixed dose buprenorphine dosing schedule here was probably based on a successful Swedish model (Kakko, 2003). However, methadone and buprenorphine should both be prescribed in tailored doses according to clinical need, using appropriate increments (e.g. 5 mg for methadone, 0.4 mg for buprenorphine). It is likely that some buprenorphine patients in this trial dropped out because they received too little or too much of the drug (32 mg is the maximum recommended dose). I could only access this abstract in English translation, so I am not able to bring further details at this point.

There is no longer any doubt that both methadone and buprenorphine are effective for substantial numbers of heroin addicted subjects treated with adequate supervised (and flexible) doses along with psychosocial supports.

From a body of research, including numerous RCT's, we know that when compared to buprenorphine: (1) methadone generally suits a higher proportion of the total and (2) it reduces the use of other opiates to a greater degree and (3) whilst in treatment, such patients are less likely to be involved in high risk behaviours. Methadone is also considered to be safe in pregnancy and is much cheaper and easier to administer. Thus methadone should probably still be our preferred first option and buprenorphine kept in reserve for particular indications. If there are concerns about patients misusing methadone, then take-away doses should be limited until stability has been demonstrated. It may be that long-term users are less likely to fare well on buprenorphine, as shown in this study.

It is unfortunate that decisions for physicians and especially for patients are frequently dictated not by clinical considerations as much as by regulatory constraints. In some countries (and for no logical reason) these are far more onerous and odious for methadone, while others artificially restrict or even ban the use of buprenorphine for addiction treatment, despite almost 20 years of favourable research.

My feeling is that buprenorphine should be available as an option to all patients who report problems taking methadone. Such patients, however, should be carefully monitored since a high proportion relapse (in this case 74% within 6 months) and

may need to transfer back to methadone or to consider other alternatives such as detoxification.

There is no indication that new combination formulation of buprenorphine (with naloxone) will be any more effective than the pure product. Some evidence points towards lowered efficacy (50% higher doses were required in one small comparative trial). While some have stated that sublingual naloxone is not relevant clinically, others have found objective changes and significant absorption (10% or more). Naloxone has a rapid serum clearance time (~5 minute half life) but its serum half life following distribution is just over one hour. While one hopes for less diversion with this formulation, Charles (Bob) Schuster writes: "It is unlikely, however, that any formulation can be developed that cannot be altered by 'street chemists' into a more abusable form."

Editor's Note: As this study indicates, buprenorphine should not be seen as a replacement for methadone. However, having a good alternative medication available, like buprenorphine, is always useful, as no one medication is going to be satisfactory for every patient.

Ideally, buprenorphine treatment would be utilized in lieu of methadone treatment for therapeutic reasons--not because onerous state regulations or poor methadone clinic practices make methadone treatment inconvenient or unavailable or because poor dosing practices make obtaining an adequate dose impossible for some patients.

Hopefully Norway has finally come to its senses and made methadone and buprenorphine treatment available and convenient to Norwegian opiate addicts in desperate need of such treatment. At least up until recently, the Norwegian methadone treatment regulations were so burdensome that virtually no opiate addicts were eligible for treatment.

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 & 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.

Doing the Right Thing (from p. 1).

(half in residential) is offered within a two-year window. There are four reasons this tremendous development is important to the recovery community that is now organizing and working to change policies about how society responds to alcohol and drug issues:

First, here is an example of a major government making decisions based on research and fact, not emotion and prejudice. Standing on the facts, the real problems can be addressed to the satisfaction of the entire community.

Second, this action proves that progress against discrimination and prejudice can be made at the state level.

Third, this public demonstration of the savings generated when addiction is appropriately addressed will bring pressure on private healthcare providers. Society will not be freed from the addiction epidemic until private insurance money returns to treat addiction.

And fourth, state government policies are good targets for successful local advocacy by the recovery community.

At the Johnson Institute, we advocate for policies that promise to "conquer addiction in our lifetime." The science to reduce our rolling epidemic to a manageable health threat already exists. It is our policies that discriminate, replacing science with prejudice. As a result, America's response to addiction disease includes the largest jail-building effort in the history of civilization.

With the example of the State of Washington, perhaps we can recognize the high cost of prejudice and the savings that happen by "doing the right thing."

Dear Methadone Today (from p. 1).

(drug related or not), even if they have been law-abiding, non-drug abusing citizens on legally prescribed methadone for ten years . . . are given clonidine and told that they should look at this as an opportunity to "get off of that methadone stuff".

Upon further investigation, I've learned that the reason methadone is given to pregnant, opiate dependent women is the same as the reason other opiate dependent inmates are given clonidine... to simply avoid potential lawsuits. Clonidine stabilizes blood pressure, minimizing the chance of withdrawal-related heart attacks or seizures. Methadone minimizes the chances of a dependent woman miscarrying during withdrawal. There is no compassion or shred of humanity involved in these decisions. They are simply financially expedient.

By the way, while my two most recent stints in county jail were during my sobriety; I was

locked up on a failure to appear warrant for 8 days (of which I wasn't aware, since I hadn't resided where the court notice was sent for two years) and again on a "late payment of fines" warrant for four days. On both of these two most recent occasions (March 2004 and June 2004), I was on 135 mg of methadone per day. I don't have to tell you how I felt by the third day of my 135 to 0 mg cold turkey. With few exceptions, the policy of MCCI seems to be repeated in the majority of city, county, state, and federal prisons throughout the U.S.A., the "Land of the Free." **-SK**

We are sorry this issue of the newsletter is so late. My computer quit, and I am borrowing one to get this issue out. I had to load all of my relevant software, fonts, etc. to this computer, and well, you know the drill when you don't have your own computer.

Thanks for your patience.

Beth

Dear SK,

Most states have little or no legal protection from jails or prisons refusing to maintain methadone patients, or even provide methadone for a short taper period. And as previously discussed in **Methadone Today**, the courts generally do not consider prisons/ jails withholding methadone from methadone maintenance patients to be unconstitutional "Cruel and unusual punishment".

So, all you can do is to try to persuade the jails to change their practices. Often this consists of asking them to dose inmates on a case-by-case basis, or contact your state lawmakers and ask them to pass legislation requiring jails to dose inmates who are methadone maintenance patients. Trying to get such legislation passed is going to be an uphill battle. Anything that

is perceived as making life easier for inmates is assumed to be politically unpopular--especially where it involves drug addicts. If that isn't enough, methadone treatment is not exactly popular with many people, including some politicians, who believe all the misconceptions surrounding it. Let's face it: politicians are afraid of doing anything that their opponents could label as "soft on crime".

However, methadone treatment advocates may eventually be able to frame this issue differently. The facts are on our side: Methadone maintenance therapy is a highly successful opiate addiction treatment, and is proven to dramatically reduce associated criminal activity. Any measure that can reduce recidivism among incarcerated convicts, such as the provision of methadone treatment to inmates, should be seen as a crime fighting measure.

We largely agree with you that certain jail policies are dictated by finances rather than compassion. Some jails have changed their policies when inmates died after the jail refused to provide their methadone dose for a period of time. The reason for the policy change was that the families of the inmates sued, and the jail feared the cost of future lawsuits.

We believe that ALL methadone patients should be concerned with the issue of jails refusing to provide methadone to methadone maintenance patients who become incarcerated. Keep in mind that many inmates have not been convicted of anything—at least, not yet; they are in jail, awaiting trial because they could not afford to make bail or because bail was denied.. Jails are just as apt to deny methadone to pretrial detainees--and even in this case, the courts have been, at best, ambivalent about whether withholding methadone from pretrial detainees, who were on methadone maintenance prior to incarceration, violates inmates' 'due process' or other constitutional rights. This means that any methadone patient that has the misfortune of being accused of a crime s/he did not commit could wind up in jail and deprived of his/her maintenance medication, even though the individual may be ultimately acquitted or the charges dropped. We must all work to change the barbaric practice of withholding a methadone patient's medication in jail.

Note: *This writer was referred to an ARM (Advocates for Recovery through Medicine) advocate who has been involved in this issue.*

Dear Mike, (from p. 1)

Thank you for reminding methadone patients, and anyone with a serious medical condition or medication allergy, how important it is to carry a medical alert card [see bottom of page 4 to order a personalized card]. Generally, opiate withdrawal is not fatal, but your medical condition at the time (i.e., breathing stopped), severe opiate withdrawal might have killed you. As you indicate, without a medical alert card, the hospital doctors may have thought you were suffering from an opiate overdose and given you Narcan—which in a methadone patient is contraindicated and would trigger very severe withdrawal symptoms. Even if not life threatening, no one would want to go through the kind of severe withdrawal Narcan would induce in a methadone maintenance patient.

It is fortunate that you had your sister and a friend there to advocate on your behalf. In most cases, continuing the methadone patient's maintenance dose is the proper course of action, but hospital doctors are sometimes misinformed. They wrongly assume that either the maintenance dose of methadone should be discontinued while the patient is given short-acting opiates for pain or that the maintenance dose of methadone will relieve serious pain, negating the need for opiate pain relievers. Having a relative and/or friend to advocate for you while you are in the hospital is always a good idea—especially since you may be in no condition to advocate for yourself.

However, the hospital doctors were correct to only give you 210 mg/d into your i.v., instead of your normal dose of 420 mg/d. According to TIP #43, "Medication-Assisted Treatment For Opioid Addiction in Opioid Treatment Programs," p. 175, "If methadone must be given parenterally, the injected dose should be 50 percent of the oral dose, because it is absorbed twice as efficiently by injection."

We are glad that you recovered and decided to write us about your experience.

Dear Methadone Today,

My husband started on methadone last week with 40 mg but he said that at the end of the day he feels sick again, and then he uses drugs again. He told me it is because he is not stabilized yet, but he is now on 80 mg and he still feels sick. So I am driving crazy with this circle, use methadone in the morning and

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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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then use drugs in the afternoon because he still feels sick.

When do you think he will start feeling ok--does he need to keep going up? Will he feel okay eventually even though he continues using drugs? **-A Concerned Spouse**

Dear Concerned,

We know that it must be frustrating to see your husband continuing to feel sick and use drugs. Given your description of what is going on, your husband may not be at a methadone dose sufficient to hold him for the entire day--or to quell opiate cravings. When you state that he is using drugs in the afternoon, we are assuming that you mean opiates . . . if he is using other drugs, your husband should be aware that certain drugs will interact with methadone. For example, using cocaine may make him feel underdosed. Alcohol speeds up the metabolism of methadone, which would result in the premature onset of withdrawal symptoms (before the time he would be due for the next methadone dose).

In all likelihood, he will respond to treatment once he is stabilized on a sufficient methadone dose. For the majority of methadone patients, the optimum dose is between 80 mg and 120 mg daily--but for some patients, the correct dose may be significantly more or less than this. Some patients need a split dose regimen, taking ½ of the daily dose twice a day. But at this point, it is probably not an issue for your husband. Try not to get too frustrated, as it has only been one week. It often takes more time than that for a patient to become stable and cease craving opiates.

Good luck to you and your husband, and please contact us if you have any more questions or problems--we do have a Medical Advisory Board [see page 2] with excellent doctors who have been generous enough to answer patient questions.

Note: This patient was contacted by us a few weeks after his note, and he says he is doing fine now.

Dear Methadone Today,

I was so pleased to find your website! My husband has been in an MMT program for almost 6 months. Much traveling is involved, and finding your website just reminded me that other people are dealing with the same issues we are and that ultimately, this methadone program has given us our lives back.

Thanks, new loyal subscriber. - SM

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