



Methadone Today

The official newsletter of DON'T--by patients, for patients

November 2006 Volume XI Number VII

ANNOUNCEMENT--Your Input Needed!

Methadone Today was originally intended to be a forum for methadone patients, family and friends of methadone patients, methadone clinic staff and other interested parties to voice their opinions, stories, and concerns. The editors of **Methadone Today** publish this newsletter as a tool to help methadone patients through advocacy and education. Please understand that the editors are VOLUNTEERS and get no compensation for creating, editing, and printing the newsletter. In fact, the editors sometimes incur costs involved with the publication of **Methadone Today**.

One of the problems the editors are having is that we are not getting enough input and material from people--especially methadone patients! **Methadone Today** cannot be the voice of methadone patients if we do not get material to publish from methadone patients. If, up until now, we have not made it clear enough--we welcome and **need** your input; that goes for not only methadone patients but for any interested parties, including family members and methadone treatment provider staff.

What concerns do you have related to methadone treatment that we have not covered to your satisfaction? The editors have tried to cover the issues we believe are important, but we surely have missed or glossed over an important issue. Tell us what issues are important to you, what has been your experience at your methadone treatment provider, and what obstacles to treatment have you faced? **Methadone Today** wants to be here to discuss YOUR issues and concerns. Also note that, in spite of the name of the newsletter, **Methadone Today** relates to all opiate agonist treatment (i.e., methadone and buprenorphine)--you are currently in buprenorphine treatment, we want to hear from you.

So, if you think that **Methadone Today** is serving a worthwhile function, we urge you to help keep it going. This requires contributions--articles, letters, etc. The editors would like to continue, but they need your participation.

We would like to continue to use **Methadone Today** to advocate for patients in opiate agonist treatment and as a forum for methadone patients and others to voice their opinions, concerns, and stories. In order to do this, we need your help and input (**See bottom of p. 4 for our contact information**).

Perils of Pain in MMT: Updated Evidence

Reprinted from Addiction Treatment Forum (Spring, 2006)

Pain in MMT patients is a significant problem affecting quality of life and outcomes of addiction treatment.

Discussions of pain conditions in patients in methadone maintenance treatment (MMT) programs and how to achieve effective pain management are not new. The subject was featured in AT Forum a decade ago (Winter 1996;5[1]) and more recently (Spring 1998;7[2]; Winter 2004;13[1]; and Summer 2005;14[3]) — all are available for review at ATForum.com.

This also was a 'hot topic' at the recent American Association for the Treatment of Opioid Dependence (AATOD) Conference in Atlanta. Increasing abuse of opioid pain-relievers (analgesics) combined with the persistent stigma surrounding MMT in general have greatly complicated pain management in this patient population, as was noted by many speakers and Conference attendees. Apparently, even after all that has been said and written, the perils of pain in MMT still present challenges for patients and staff alike.

New research and commentary reported in the literature add further perspectives for dispelling some misconceptions behind the mistreatment of pain during MMT. Along with that, there have been some suggestions that MMT patients actually may be more sensitive to pain, which has implications for effective pain control. Although the discussion below focuses on methadone, it should be noted that the same general principles apply in patients administered buprenorphine for opioid-addiction therapy.

Misconceptions & Mistreatment

As reported previously in AT Forum, pain is a prevalent problem in MMT patients; up to 80% in some clinical surveys noted pain in a typical week, and more than half experienced long-lasting, chronic pain conditions. The prevalence rates may vary in particular MMT clinic populations; although, there is no doubt that pain in these patients is a significant problem affecting quality of life and outcomes of addiction treatment.

(Cont. p. 3)

A few months ago, I received the medical examiner's report. I honestly did not open the envelope until recently. I had a good idea of what caused my mother's death because I had spoken to the medical examiner on a few occasions prior to her completing the report.

The cause of death is listed as "Dilated and Hypertrophic Cardiomyopathy, and methadone intoxication as a contributing factor. It appears she had a high level of methadone in her system she obtained from some place other than her clinic.

For the last eight months, I have tried very hard not to think about her death and how she was treated at her clinic. I know I need to think about it and accept she is no longer alive, but it has been too painful, and as a result, I have been avoiding dealing with her death. I immediately focus my thoughts on other things. But I need to start that process. And, part of the process is finding closure. I need to seek justice for my mother. Her clinic should be held responsible for the lack of treatment she received and the inhumane way she was treated. Aside from the letter, I have other supporting evidence of the clinic's bias toward my mother. I am determined to pursue legal action against her clinic. (Cont p. 4)



Dear Methadone Today,

I have been browsing through the newsletters on your website. I have been sitting here for hours with tears in my eyes from the stories I have been reading that remind me of the problems my mother encountered at her clinic. My mother was on methadone for more than 20 years.

I am angry, outraged, sad, and frustrated about how my mother was treated at her clinic in the months leading up to her death. I would like to share with you a letter I wrote to the President of the OTP (his office is not located at the clinic) at my mother's clinic just one month before her death [see the letter on page 2]. Tragically, nothing was done to save my mother. In the letter, it does not mention all the negativity my mother received at the clinic. I tried to keep the letter positive and place the focus on the methadone dosage in question - that was my primary concern for my mother. When that issue was corrected, I was then going to address the negative treatment my mother was subjected to at the clinic. Unfortunately, I didn't have that opportunity.

Dear Grieving Daughter--Letter to provider president (from p. 4).
[The following is a letter written to the president of the methadone treatment provider. As indicated previously, the subject of this letter--the writer's mother--died a month after this letter was written. Names of the parties have been omitted/changed, given the probability of litigation].

Dear Mr. X [President of Company Y]:

Please allow me to introduce myself. My name is M. I am the daughter of D, a patient of the Clinic C, a Company Y clinic.

Let me start by saying that I understand you are an extremely busy person, however, I feel it is necessary for me to share with you a major hindrance in treatment my mother is receiving at Clinic C.

My mother has been a patient of Clinic C for approximately 10 years and has been using methadone for least 15 years. Although she has not used opiates during this time, she has become dependent on methadone. For the last ten years, my mother has been receiving a methadone dose between 80-120 mg. My mother also suffers from mental illness, among other health issues. She has not had recent contact with a psychiatrist and therefore has not had access to medication to treat her illness. I am happy to say she has an appointment on February 8 to be evaluated.

The last few months have been very tumultuous for my mother and our family. In November 2005, my mother was hospitalized for approximately 2 ½ weeks due to pneumonia and severe hypothyroid. During her hospital stay, Dr. R, a hospital physician overseeing my mother's condition decided to reduce her methadone dose from 120mg down to 80mg, and from 80mg to 50mg. He ultimately discharged her at 30mg per day in the short span of 2 ½ weeks. Dr. R was unaware of my mother's history of methadone use.

Upon my mother's release from the hospital, I met with her Clinic C counselor, and Clinic C physician, Dr. F. I informed them that upon my mother's release, her current dose was 30mg. It was decided amongst those in the meeting to keep her at this dose. My mother was not in this meeting and was unaware she was receiving 30mg.

Immediately, my mother began experiencing severe withdrawal symptoms. She continuously complained to both Clinic C staff and to myself. I began to realize the drastic and rapid decrease of her methadone dose was the cause of her discomfort. I accompanied my mother to a counseling session to discuss her condition with the Clinic C staff. Her repeated requests for an increase were denied. Only after involving her medical doctor and a mental health case management worker to advocate for my mother was her dose increased by 11mg. Currently my mother is receiving a 41mg methadone dose.

After two months my mother is still feeling the symptoms of the low dose she is receiving. She has become depressed. Her thoughts are consumed by this ordeal. She doesn't sleep at night. She's experiencing rapid weight loss and many, many other symptoms. Only recently have I heard my mother mention the urge to use heroin. My mother feels a dose between 50-60mg would help her continue on a positive path and abstain the urges to use heroin.

Clinic C has refused to increase my mother's dose indefinitely despite our repeated communications of her symptoms.

Dr. F cited the refusal for any dose increase is due to the lack of visible withdrawal symptoms, lack of mental illness treatment, and lack of recent opiate use. Also cited was the improved physical appearance my mother has shown. While I agree with Dr. F that my mother looks better than she has in the past, an important component is that she has been compliant in taking her medications to treat her diabetes, thyroid, etc. Medications she was not properly utilizing in the past. I also agree that it is important my mother receives treatment for her mental illness but I believe allowing her to feel so much discomfort is unacceptable.

I am afraid for my mother. I feel she is at high risk for using illicit drugs again. I know with proper treatment this can be avoided.

Mr. X, I am pleading for your intervention to assure my mother receives proper treatment at Clinic C. Please do not let our concerns go unanswered. We look forward to your assistance.
 Sincerely, Grieving Daughter

Perils of Pain in MMT (from p. 3).

According to anecdotal reports, maintenance methadone doses have been tapered or withdrawn before or after surgery (perioperative), resulting in considerable distress and discomfort.

In brief, there is no rationale for tapering an opioid-dependent patient off opioids in the perioperative setting. All practice guidelines regarding pain management require that maintenance opioids be continued in the opioid-dependent patient who is about to undergo surgery. Along with that, a full range of pain-control measures should be instituted as aggressively as needed to relieve any perioperative pain (McCarter 2006).

Before or upon hospital admission, it is important that hospital staff verify the patient's methadone dose with the respective MMT clinic. It is equally crucial that the hospital communicate with the MMT program at the time of discharge to make clinic staff aware of any controlled substances that were given to the patient and would be detectable during routine drug testing.

Pain Management Summary

The review by Alford et al. (2006) provides specific recommendations for pain management in patients on methadone or buprenorphine maintenance for addiction, and interested practitioners should consult that article. By way of summary, several general principles outlined in that article and previously in AT Forum are listed [see below:]

Managing Pain During MMT

- »»MMT patients need appropriate analgesia, including opioid medications, just like any other persons with acute or chronic pain.
- »»However, MMT patients may need short-acting opioid analgesics more frequently and in larger doses.
- »»Mixed agonist and antagonist opioids must be avoided since they can cause acute withdrawal.
- »»Most, but not all, research indicates that MMT patients with pain require higher daily methadone doses.
- »»An adequate methadone-maintenance dose should be continued when initiating pain therapy; prior detoxification from or reductions in methadone is counterproductive and can negatively affect the health of the patient.
- »»Blockade and cross-tolerance effects of adequate methadone maintenance dosing protect MMT patients from euphoric effects, drug craving, and/or respiratory depression associated with large doses of short-acting analgesics.
- »»Concerns regarding respiratory depression or reduced brain (central nervous system) activity and addiction relapse due to opioid analgesia are generally unfounded.
- »»However, patients' fears of relapse into prior substance abuse should be acknowledged and appropriate supervision, follow-up, and relapse-prevention support provided.

Perils of Pain in MMT (from p. 1). Methadone Provides Pain Relief?

A recent and thorough review by Alford et al. (2006) addressing pain management in MMT patients presented 4 common misconceptions that often result in mistreatment. The first is that during MMT methadone provides pain relief (analgesia). Although methadone is, indeed, a potent and effective opioid analgesic, during long-term MMT in which the patient typically receives once-daily dosing there are no substantial pain-relief benefits. Methadone is dosed entirely differently for analgesic purposes and its duration of pain-relieving action is only 4 to 8 hours. Furthermore, stabilized MMT patients become tolerant of any pain-relieving effects; that is, as the patient becomes accustomed to the medication it loses potency as a pain reliever.

Therefore, any pain relief afforded by methadone would be short-lived at best and insufficient in the MMT patient with significant pain. Also, the tolerance of opioid analgesic effects, which extends to any opioid-class medication, helps explain why MMT patients usually require higher, more frequent doses of short-acting opioids to achieve adequate pain control.

Along with this, experiments have suggested that patients maintained on opioids can develop a heightened sensitivity to pain, which counteracts any pain-relieving benefits that might otherwise be afforded by methadone. This is discussed later below.



Methadone Plus Opioid Analgesics is Dangerous?

Alford et al. (2006) state that physician's concerns that opioid pain relievers in combination with methadone maintenance will harmfully depress breathing or brain activity is "a theoretical risk, which has

never been clinically demonstrated."

For one thing, persons maintained on opioids become tolerant of the respiratory and nervous system depressant effects. It also has been suggested that the stressful physiological responses to pain serve to counteract those effects.

[The lack of evidence to support concerns about severe drug toxicity with analgesic-opioid therapy in MMT patients would not appear to rule out the potential for harmful opioid overdose if the analgesic is not appropriately prescribed and administered. Also, the combination of multiple long-acting opioids – e.g., methadone plus sustained-release morphine – is not advised, since their effects might accumulate and increase unpredictably over time (Kral 2006).]

Opioid Analgesia May Produce Addiction Relapse?

There is no evidence that exposure to opioid analgesics for the relief of pain increases relapse rates in MMT patients, according to Alford et al. (2006). Small studies involving MMT patients reported no differences in relapse rates between those receiving opioid analgesia for pain and those without pain. In contrast, principles of relapse prevention would suggest that the duress of unrelieved pain would be more likely to trigger drug relapse than adequate pain relief afforded by any means. Clinical surveys of MMT patients have found that unrelieved pain can play a significant role in initiating or continuing substance abuse (Karasz et al. 2004).

Pain Complaints Are a Form of Drug-Seeking?

All physicians are concerned about being manipulated by patients who are seeking prescribed analgesics for non-medical purposes, and this might be of special concern in addiction treatment settings. However, the experience of pain is subjective, making clinically objective assessments of its presence and severity difficult. Still, Alford et al. (2006) suggest that careful clinical examinations for objective evidence of pain can be

important for determining legitimate requests for analgesics. Reports of acute pain, supported by objective clinical findings or plausible causes, may be more readily considered legitimate than complaints of chronic pain that is only vaguely described. Which is not to say that poorly defined reports of ongoing pain should be dismissed as merely drug

seeking.

Many of the behaviors in MMT patients, and others, often deemed to be drug-seeking might be explained by the mistreatment of pain or a fear of such by the patient. In this regard, Alford et al. (2006) mention several terms of interest, derived from the literature:

-Pseudoaddiction – inadequate pain relief motivates the patient to seek alternate formulations, amounts, and sources of opioid analgesics, which results in seemingly aberrant or addictive behaviors.

-Therapeutic dependence – sometimes patients exhibit what is considered drug-seeking because they fear the re-emergence of pain and/or withdrawal symptoms from lack of adequate medication; their ongoing quest for more analgesics is in the hopes of insuring a tolerable level of comfort.

-Pseudo-opioid resistance

Other patients, with adequate pain control, may continue to report pain or exaggerate its presence, as if their opioid analgesics are not working, to prevent reductions in their currently effective doses of medication.

MMT patients' fears of inadequate analgesia or other mistreatment by healthcare practitioners are often based on the stigma and prejudices against methadone and persons with addiction that they have experienced in the past. Patient anxiety related to such concerns can be profound, resulting in demanding or aggressive behaviors that are misunderstood by healthcare practitioners and detract from the provision of adequate pain relief.

It is important to consider that chronic pain in MMT patients has been linked to psychological problems, social isolation, and polysubstance abuse. In many cases, patients complain that healthcare providers express a lack of concern, do not listen to them and, consequently, do not effectively treat their pain. Researchers suggest that pain management approaches in these patients should emphasize emotional support, taking into account the psychosocial effects of pain (Ilgen et al. 2006; Also see AT Forum, Summer 2005;14[3] for references).

Concerns About Perioperative MMT

MMT patients often are worried about pain management during hospitalization for surgical procedures. (Cont. p. 2)

Dear Methadone Today (from p. 1).

This is where I could use your assistance. I need to know where I can find an attorney who is familiar with methadone. Someone who is truly concerned about the injustices some patients face.

Please help me! **-Grieving Daughter**

Dear Grieving Daughter,

We are sorry to hear of your mother's death--such a loss is always difficult to deal with, but your mother's death is especially sad, since it may have been preventable. We are not attorneys, but judging from your letter to the president of the treatment provider, it sure seems like your mother's methadone clinic was negligent and guilty of malpractice. Perhaps your lawsuit will help prevent other patients at this methadone clinic from suffering--even if most of the patients do not actually die as a result of their practices, they still may be suffering, albeit to a lesser extent than what your mother went through.

Part of the blame for your mother suffering goes to the hospital physician that rapidly tapered your mother from 120 mg all the way down to 30 mg in only 2 1/2 weeks. As a matter of fact, you may want to inquire about suing this doctor in addition to your mother's methadone clinic. Even assuming your mother had been a good candidate for tapering off of methadone AND had requested such a taper, the speed of this taper was way too rapid. If our math is correct, that is an average reduction of 5 mg/day. A reasonable taper from 120 mg down to 30 mg should take at very least about 6 months. In any event, we doubt that your mother was a 'good candidate' for a methadone taper at that time, and from the wording of your letter, we gather that your mother had not requested such a taper. In our opinion, such an involuntary taper by a hospital doctor that is neither the patient's methadone treatment physician, nor an addictionologist is completely unethical.

We simply cannot grasp why a hospital physician thinks it is any of his business to taper a methadone maintenance patient off of methadone without the patient's permission and without consulting with the patient's methadone clinic. How many other methadone patients has this doctor rapidly tapered while they were being hospitalized for a condition unrelated to opiate addiction? In addition to the pain and suffering caused by withdrawal symptoms that occur when a methadone patient is tapered this rapidly, the consequences of a rapid taper are severe--the most likely consequence is a relapse to illicit opiate addiction, in which case the individual could fatally overdose, contract

hepatitis C or HIV from i.v. drug abuse, or wind up in jail for the purchase, possession, or use of illicit drugs [or even for crimes committed to support the illicit drug habit, in the case of a full blown relapse]. You may want to include the hospital doctor in your lawsuit, if only to try to prevent him from rapidly tapering other methadone patients.

As for your mother's methadone clinic, we clearly think that the clinic physician was wrong. They ignored her complaints about withdrawal symptoms and pleas for help. They chose not to increase your mother's dosage even though they knew that she had been rapidly tapered from 120 mg to 30 mg in a very short period. Even in the case of a more reasonable taper, a good methadone clinic will allow a patient to get an increase if s/he starts experiencing serious and persistent withdrawal symptoms. This clinic physician either is incompetent and/or has no compassion whatsoever if he believes that after rapidly tapering from 120 mg to 30 mg, your mother is just making up or imagining the withdrawal symptoms she is complaining of. In any case, an adequate maintenance dose of methadone not only suppressed withdrawal symptoms, it also prevents drug cravings--and clearly your mother was having drug cravings.

The methadone clinic physician's reasons for denying repeated requests by your mother for dose increases are far from compelling and reveal an anti-patient mentality. Among other examples of his anti-patient mentality is the fact that he discounted your mother's complaints about withdrawal symptoms and drug cravings. If this doctor insisted on objective evidence of withdrawal, he should have ordered a methadone blood plasma test for your mother--a blood plasma test is administered to determine whether the patient has a sufficient level of methadone in his/her blood. This test is far from foolproof, but at least it might have objective evidence that your mother was underdosed and needed an increase.

If your mother's methadone clinic had not ignored her pleas, perhaps she would not have died. From the autopsy results, it seems very likely that your mother was so desperate to alleviate her withdrawal symptoms that she supplemented her prescribed methadone dose with methadone she obtained illicitly--with fatal results. We wish you luck with your lawsuit, and also hope that you find the closure you seek. We can privately discuss your request regarding the selection of an attorney.

Editor's Note: We have printed a copy of the letter this grieving daughter sent to the president of the treatment provider prior to her mother's death, detailing the treatment her mother was receiving at her methadone clinic. **(See letter on p. 2)**

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