

Methadone Today

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Fear Clouds Role of Effective Treatment

by Peter Moinechen (CAP Quality Care)

Methadone ignorance can be combated by education, and the science that backs up this education is indisputable. But facts do not impact fear. Fear is a primitive emotion. I believe one component of this fear is that opiate addicts do not want to own that chronic disease called protracted endorphin system derangement.

Some addicts' systems will re-balance themselves during abstinence. These should be the most grateful. Others, due to biology beyond their control (powerlessness), find their opiate receptors starving for endogenous opiates throughout their lives. For these, the comfort of stability is an unattainable goal without the introduction of exogenous opiates. The introduction of medicine to treat a disease is usually met with hope, but the medicine that is methadone is met with jeers.

Could fear be fueling these negative beliefs? Fear that if I did a searching inventory of my health status, I may discover that I function at an improved level when more of my opiate receptors are filled. If comfort and recovery are to be married, for many opiate addicts, methadone must be the best man.

Discomfort and instability are not hallmarks of recovery--rather, quality of life, improved function, and increased range of choices are what we strive for. To condemn someone to the ravages that accompany the brain disease of addiction when effective medicine is available is unconscionable and rather should be emphatically embraced as a viable, authentic tool that saves people's lives. For 12-step programs to deny the benefits of their meetings, deeper contact with our spiritual nature, and fellowship to methadone-maintained recovering persons is a crime that cries out for redemption.

Editor's Note: Bravo--very eloquently put.

My Pet Peeve: "Dirty Urines"

Some MMT people are still using illicit drugs. Saying that we are "clean" implies that they are "dirty". I don't agree with the terminology, and I'm trying my best not to fall into the habit of using it again. I want to be called a patient instead of a client, and my urine screens are not "dirty" or "clean", they are positive or negative. Instead of saying I am clean, I say that I have been compliant or simply that I have not used any illicit drugs.

That's just a pet peeve that we should all have IMHO (in my humble opinion). It implies that we don't deserve respect if we are "dirty." Some even think this means we are immoral. They do not understand that we have a disease. When they hear us use these words, their image of thieves and murderers are reinforced.

I believe the reason more methadone patients are not compliant with their clinics is because they are not educated. They do not know that they are sick; they think they are bad. They do not have pride in the fact that they are getting treatment. They are ashamed of the treatment. They feel like they have to hide the fact that they are taking methadone.

Drug Interactions

[The follow is reprinted from the handbook, "About Methadone," published by The Lindesmith Center-Drug Policy Foundation.]

Like any medication, methadone can interact with other types of medicines and with street drugs. The body is a complex system, and it's possible that foods, hormones, weight changes, and stress may each also affect the way in which methadone works in your body.

We know about some of the substances that may interact with methadone--and some of them are listed here. Others may yet be discovered.

- These medicines cause the liver to metabolize methadone more quickly and may cause a need for an increased methadone dose:
 - Carbamazepin (Tegretol)
 - Phenytoin (Dilantin)
 - Nefopidine (Viramune)
 - Rifampin
 - Ritonavir (Norvir)--less of an effect
- Some medicines slow the metabolism of methadone. Sometimes people will feel the effect of methadone more strongly when they take these medications, and sometimes they experience withdrawal symptoms when they stop taking these medications:
 - Amitriptyline (Elavil)
 - Cimetidine (Tagamet)
 - Fluvoxamine (Luvox)
 - Ketoconazole (Nizoral)
- Some medications are opioid blockers and may cause withdrawal. These block the effect of methadone and SHOULD NOT BE TAKEN if you are taking methadone:
 - Pentazocine (Talwin)
 - Naltrexone (Revia)
 - Tramadol (Ultram), in most cases
- Some medications initially interact with methadone to cause sedation, but then the opposite occurs, and they can cause withdrawal symptoms. These medications include: (Cont. p. 2)

Most clinics do nothing to educate their patients. Patients think they are in a power struggle and are being manipulated. That is why they use. We are strong and stubborn people. We will find a way to not be controlled. Some of us know no other way to be in control of our destinies. Clinics make us feel like we have no say in our own treatment. We will use to prove them wrong. We will use to show them they are wrong. We will use because they do not give us any incentives not to use. We use because we are treated like we just used yesterday even if we have been compliant with the program rules for years. We are treated like we cannot be trusted. We have nothing to lose by using. Are we going to lose the respect of our clinic staff? No, because we never had it anyway!

If they would allow us to have access to the truth, they would have more success in this treatment modality. I am advocating for patients in my clinic to have a bulletin board. It is an uphill battle. I was told that they (staff) are afraid that we will leave coded messages to each other on it! That is the mentality we are fighting! (Cont. p. 3)

Dear Doctor,

I have heard people say that methadone keeps them from drinking [alcohol]. Is that possible and if so, how? **-Emily**

Dear Emily,

Alcohol interacts with the same endorphin receptors that methadone and other opioid drugs affect. Filling up these receptors with another substance, whether it blocks (like naltrexone) or stimulates (as with methadone), diminishes the amount that alcohol abusing rats or humans will drink. (You can look this up in Medline. J. David Sinclair, Ph.D., is usually one of the authors. The work goes back to the 1970s, I am guessing).

Alcohol-preferring rats given morphine will take it to the exclusion of alcohol after awhile. In the absence of morphine, opioid-dependent rats allowed access to alcohol will cross over to alcohol dependence. They will cross back to morphine if given the opportunity.

A heroin addict who cannot get enough heroin may use alcohol. If he gets enough heroin, he will not use alcohol at all. Some never get enough.

After dependence and tolerance are developed to alcohol and/or opiates, the craving and associated behaviors are, in our experience, completely diminished by adequate doses of methadone with good results in all areas of function.

Very few previously dually-dependent patients choose to replace opiates with alcohol once having enjoyed the benefits of having their endorphin dysfunction stabilized with opiates. Methadone and LAAM are the ones that we use.

There are exceptions, but in our clinics, I cannot recall any patients who abused alcohol after getting an adequate methadone dose. Those who do abuse it usually have serious problems such as rapid progression of Hepatitis C-related illness and/or overdose.

Marc Shinderman, M.D.
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Editor's Note: Consistent with these findings, naltrexone has been found to be an effective treatment for alcohol addiction in patients who are NOT opiate addicts.

It is very important that clinic physicians--and even counselors understand this. The equation becomes more complicated because alcohol speeds up the metabolism of methadone. When alcohol is first ingested, it will boost the effect of the methadone. Thus, some patients actually drink to compensate for an inadequate methadone dosage, but in the long term, this is worsening the problem. Counselors not aware of the interaction between alcohol and endorphin receptors may approach alcohol abuse as an unrelated problem; in doing so, they may fail to see the big picture. If the patient is not also abusing opiates, it would never occur to a counselor [or even a physician] to question the adequacy of his/her methadone dose.

Patients, too, need to educate themselves. Many methadone patients who abuse alcohol do not realize that drinking is actually making them get sick [withdrawal symptoms] sooner. Perhaps they would have asked for a methadone dosage increase sooner had they known that this may relieve alcohol cravings. Obviously there are many risks associated with excess alcohol consumption, but alcohol abuse is a particularly urgent problem among methadone patients because of the high incidence of Hepatitis C infection in this population. Depending on the area of the



U.S., upwards of 90% of methadone patients are infected with Hepatitis C. The use of alcohol is very problematic for Hepatitis C patients--alcohol may speed up the progression of the infection. In addition, Hepatitis C often affects liver function--and alcohol is particularly hard on the liver. It is recommended that anyone infected with Hepatitis C not drink any alcohol at all.

Drug Interactions (from p. 1)

- Benzodiazepines such as Xanax and Valium
- Alcohol
- Barbiturates
- Other medications with interactive effects:
 - Cocaine can increase the dose of methadone required.
 - Methadone increases the level of AZT and desipramine in the blood.

Two things should always be kept in mind regarding methadone interactions:

- Methadone is not responsible for every new feeling you have, and it won't be affected by most medications or changes in your life conditions.
- If your methadone dosage doesn't feel right, it probably isn't right. You are the expert when it comes to how much methadone is enough. Talk to your doctor about how you're feeling.

Editor's Note: Because of the potential for reactions between methadone and other drugs, we highly recommend that all methadone patients carry a medical alert card and/or bracelet (a personalized medical alert card may be ordered from **DON'T/Methadone Today** [see bottom of page 4]). Well-intentioned medical personnel, if they do not know you are on methadone, may make a bad situation worse. For example, administration of opiate antagonists or "opioid blockers" [see above] may cause a worse problem than that for which you were originally being treated.

Unless you have certain specific medical conditions, you are unlikely to come across many of these medications, but some prescribed drugs which interact with methadone are commonly used. For example, many dentists prescribe Talwin for pain following minor procedures. If your dentist or physician is not aware that you are on methadone [or even if he is], it is advisable that you double check the name of the prescribed medication before you get it filled and take it.

Regarding medications which slow the metabolism of methadone, it is worth mentioning that some of these medicines have a greater effect on methadone metabolism than others. Cimetidine (Tagamet) is actually available over-the-counter for stomach problems (excess acid, indigestion, etc.) and if taken at the dosage recommended on the over-the-counter product label, is unlikely to have much of an effect on methadone metabolism--a methadone patient may notice a mild difference. On the other hand, the anti-depressant Prozac could possibly precipitate a methadone overdose. In any case, the best advice is to not take any of these medications without consulting a doctor. In the case of prescribed medications, the doctor should be informed that the patient is on methadone--preferably before the medication is prescribed.

Fear & Ignorance

Many opiate addicts contemplating methadone maintenance treatment experience fears which are created or fueled by



ignorance. Some make a point of warning their fellow addicts of the supposed dangers of methadone treatment--we can only guess what the reasons or motivations are behind these warnings. How many opiate addicts have heard that the "addiction" to methadone is worse than heroin addiction or that methadone clinics' sole mission is to get you hooked on methadone? In general, family and friends who are not opiate addicts are unlikely to have anything more positive to say about methadone treatment.

As Moinechen discusses (p.1), such myths and negative attitudes are also perpetuated by the "recovery community". The vast majority of opiate addicts' first contact with treatment or recovery programs is not with a methadone clinic but rather with a twelve-step group or an abstinence-based treatment provider, many of which adhere to the twelve-step philosophy.

Many twelve-step groups, far from providing education regarding opiate addiction and treatment, discourage or even downright bash maintenance treatment. Few providers of abstinence-based treatment have anything good to say about methadone treatment either, and it is not in their financial self-interest to provide accurate information about methadone treatment. So not only are opiate addicts hearing bad things about methadone from fellow addicts but also from those who are supposed to be assisting with recovery.

In all likelihood, an opiate addict considering methadone treatment has heard loads of negative and untrue things about it and nothing good. No wonder they are fearful of methadone and the prospect of having to remain on methadone long-term or permanently [otherwise be uncomfortable or addicted to illicit opiates]. This kind of fear is amenable to education. Moinechen makes some excellent points. Providing individuals with the facts is not enough to ease fears, especially when they have been inundated with myths perpetrated by everyone from family to recovery groups.

"Dirty" Urines (from p. 1)

I am meeting with my program director again tomorrow. She has decided that I have not been "clean" long enough to be the first federal exception they ask for. I am at 110 mg, and they do not want to give me my take-homes. I am so frustrated. I am going to have to take a decrease in my medicine in order to get them. I will not stop fighting even when I get them back.

Dear Anonymous Patient:

Thank you for allowing us to reprint your post from an Internet discussion list. You raise some interesting issues. First, we completely agree with your complaint regarding the use of the term "dirty" to describe illicit drug use/urine samples which test positive for illicit drugs. We are not sure how this term originated. Sometimes knowing how a term came into usage helps to make an argument for why it should no longer be used. For example, the term "detoxification" is based on outdated beliefs regarding drug addiction and physical withdrawal. Basically, it was thought that these drugs were "toxins", which built up in the body causing withdrawal symptoms.

We now know that this is not what causes physical withdrawal, and the term "detox" is completely inaccurate. For this reason, some methadone treatment physicians use the term "taper" to describe the process/treatment by which a patient's methadone dosage is reduced over the course of time with the goal of abstaining from methadone and opiates completely. However the terms "dirty" and "clean" came to be, we believe that they should no longer be used--and certainly not by methadone treatment staff. At best, we feel that it is unprofessional for medical personnel to use these slang, demeaning terms.

While we may concur with many of your criticisms of methadone clinics and the attitudes of many clinic staff, we do not believe that any of these are the main factor in continued illicit drug abuse by patients. At risk of generalizing, we maintain that improper dosing accounts for much of the illicit drug abuse by maintenance patients--especially abuse of opiates but also other drugs, including cocaine and alcohol [see page 2].

Keep in mind that there is a correlation between the sort of clinic staff attitudes and practices you describe and poor treatment outcomes, since staff who do not understand opiate addiction in general and methadone maintenance treatment in particular will not provide the proper treatment. In other words, it is unlikely that

patients in such clinics are being adequately dosed.

Moreover, such clinics may not deal with the mental illnesses that some patients have in addition to suffering from opiate addiction. We have heard of instances where clinic staff fail to diagnose or ignore the presence of mental illness in a patient and instead attribute problems to a lack of motivation or desire to quit using illicit drugs, comply with program rules, etc. For example, one patient we know was written off by the first clinic he attended as not being serious about recovery, but the same patient made great progress when he went to another clinic, which has an on-site psychiatrist and a great deal of experience treating "dually diagnosed" patients.

Your clinic seems to fit our characterization above--that in addition to your criticisms, they have a tendency to not adequately dose their patients. Case in point is that you had to reduce your dose to keep your take-homes. Your clinic does not want to give you ANY take-homes unless you decrease your dose. You speak of "federal exceptions", but this makes no sense, unless you meant "state" instead of "federal", as state regulations vary widely. Under the former federal regulations (*this post was written prior to the new federal regulations going into effect), obtaining take-homes when above 100 mg was a simple process--either your clinic physician misunderstood the federal regulations or deliberately misled you.

On the bright side, since the adoption of the current federal regulations, treatment providers cannot use the federal regulations as an excuse not to raise a patient's dose above 100 mg or to rescind take-homes if a patient's dose is increased above 100 mg. There is no room for confusion in the current federal regulations--no special procedure or "exception" is required to obtain take-homes for patients whose dose is above 100 mg. Thus, if a clinic denies a request for take-homes based on the patient's dose, this is a clinic decision or policy (or possibly per state regulations--check your state regulations to verify), and not the result of federal regulations.

In Memorium - Nancy Rose

passed away February 4, 2002. Nancy was one of the first members of DONT and a frequent contributor to **Methadone Today**. She was also a wonderful patient advocate.. As a contributor, advocate, and especially as a friend, she will be sorely missed.

Extended Take-homes--Dry vs. Liquid

As states grapple with amending their regulations pertaining to take-home rules, a few issues have arisen specifically pertaining to the provision of 14-30 day take-home supplies, which are permitted in the new federal regulations. One such issue, which has recently received attention from patient advocates, is whether patients receiving larger take-home supplies are permitted to obtain their medication in dry form. Until recently, when the new federal regulations went into effect, methadone patients received methadone in liquid form, or diskettes were crushed and water was added. However, note that exceptions were made for medical maintenance pilot programs where patients received a month's worth of take-home doses. In the medical maintenance setting, it made sense to provide dry medication.

There are more than a few practical problems with using liquid for extended take-home supplies--especially for a 30-day supply. To begin with, patient advocates have questioned whether the liquid medication will keep for an entire month. The main concern is not that the medication will lose its potency in one month but whether germs may grow in the solution during this time. All liquid formulations of methadone do contain preservatives to slow the spoilage process--at least in theory, the liquid medication should not spoil in a month. However, advocates are concerned about the addition of water or juice to liquid medication by the treatment provider before dispensing. Many methadone clinics do this.

According to Marc Shinderman, M.D., the manufacturer [in the case of at least one methadone formulation] recommends it on the product label/ literature. Some clinics may be doing this to deter medication diversion, and others may simply be following the manufacturer's recommendations. Adding liquid to the medication has the potential to create problems with spoilage for two reasons: doing so may precipitate spoilage by diluting the preservatives in the medication, and adding a liquid such as tap water may actually cause spoilage by directly introducing germs into the solution. Though water out of the tap is suitable for drinking and contains a certain amount of chlorine, it is certainly not germ-free, and these germs can cause problems if allowed to grow.

One obvious solution for the problem of spoilage is to refrigerate take-home doses. But this is simply out-of-the-question for anyone who shares a household with children, and refrigerating take-homes is discouraged by treatment providers even where there are no children, just to be on the safe side. Besides, many people simply do not have room for 30 take-home bottles in their

refrigerator, and others may be uncomfortable with their guests opening the refrigerator to find methadone take-homes.

Another problem has to do with the actual dispensing of extended take-home supplies in liquid form. Dispensing 14-30 take-home doses is a time-consuming affair. Typically, clinics dispense take-homes while the patient waits; this would be problematic with so many doses at one time. In the case of computerized dispensing, many clinics have the dispenser in front of a window, so the patient can see the dispensing process and be confident that no mistakes or tampering is taking place. With extended take-home supplies, liquid medication would probably have to be dispensed beforehand. But this way, patients would have no way to be certain that the doses were not tampered with. To be sure, theft of medication by clinic staff is a fairly rare occurrence--rare, but certainly not unheard of.

Over the years, several patients have contacted **Methadone Today** regarding cases of medication tampering by clinic nurses. Theft does not present the same problem when dry medication, pills or tablets, are used. Whether dry medication is dispensed beforehand or not, patients only need to count the pills to make sure that the correct amount of medication was provided--any shortage due to mistake or theft would be easily detected. As uncommon as medication theft may be, it is in the best interest of patients to be able to verify that dose tampering has not taken place.

The reason that liquid medication was required to begin with was to deter diversion. Those who cling to the argument that liquid medication is effective at deterring diversion should at least acknowledge that there is no reason to require liquid forms of methadone for those receiving extended take-home supplies. Patients receiving extended take-homes have already been determined to be stable, trustworthy, and very responsible in their handling of take-home medication. The federal regulations do not even require them to take a dose at the window when they pick up their extended take homes. Thus, there is no reason to require that medication being dispensed to patients receiving extended take-homes be in liquid form--diversion is not an issue for these patients.

In conclusion, states must not prohibit the use of dry forms of methadone--at least for extended take-home supplies. Methadone in liquid form is simply not feasible or convenient when more than a week's supply of medication is to be dispensed and carried at one time. And in some situations, liquid medication actually presents serious hardships for patients (i.e., patients who travel have to carry multiple bottles). It is in the best interest of all parties to provide extended methadone take-homes in dry form.

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