

About Methadone and Buprenorphine

Revised Second Edition

**A Drug
Policy
Alliance
release.**

We are the Drug Policy Alliance and we envision a just society in which the use and regulation of drugs are grounded in science, compassion, health and human rights, in which people are no longer punished for what they put into their own bodies but only for crimes committed against others, and in which the fears, prejudices and punitive prohibitions of today are no more.

Please join us.



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Table of Contents

3	Acknowledgments
4	Introduction
6	Dependency
8	What is Methadone?
10	Buprenorphine
11	Maintenance
13	After Methadone
14	Myths & Facts
16	Drug Interactions
18	Your Other Doctors
19	Methadone & Women
21	Storing Methadone
22	Concerns about Overdose
25	In Case of Overdose
26	Detoxification
28	Methadone & Pain
29	Driving
30	Traveling with Methadone
32	State Substance Abuse Agencies
33	Other Resources

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This second edition has been revised to include information about buprenorphine, an important treatment option that has emerged as an additional opioid addiction treatment to methadone. Future editions of *About Methadone and Buprenorphine* will provide readers with more comprehensive information about opioid addiction treatment using buprenorphine.

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Holly Catania, JD

Baron Edmond de Rothschild
Chemical Dependency Institute

Introduction

You may be reading this book because you are taking methadone or because you are thinking about taking methadone – or because you care about somebody who is.

People usually enter methadone treatment because they feel overwhelmed by their dependence on heroin or other opioids. But not everyone who comes into methadone maintenance has the same goals. Some people want to stop taking street opioids for good. Some want to temporarily stop taking street opioids. And some want to reduce or re-regulate their use of street opioids.

Some people begin methadone with the belief that they will need medication indefinitely. Others feel that they will only need it for a short time. Regardless of what you hope to get from methadone maintenance, however, all the evidence agrees on these several points:

- People dependent on street opioids who receive methadone treatment are healthier and safer than those who do not. They live longer, spend less time in jail and in the hospital, are less often infected with HIV, and commit fewer crimes.
- Longer periods of methadone maintenance are better than shorter periods. The longer you stay on methadone maintenance, the better the overall outcome. Indefinite treatment often means life-long extension of good health, HIV seronegativity, and freedom from incarceration.
- Methadone maintenance is treatment for people who are dependent on opioid drugs. It is not a treatment for people whose major problems are with other drugs – such as cocaine, alcohol, benzodiazepines, or cigarettes.

Opioid drugs include all the drugs that come fully or partially from opium and synthetic drugs that have similar effects. Morphine, heroin, codeine, methadone, dilaudid, buprenorphine, LAAM, OxyContin, and fentanyl are opioids.

People dependent
on street opioids
who receive
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Dependency

Opioids have been used for thousands of years, and it has long been known that many people who have become dependent on opioids have extreme difficulty permanently ending their use of them.

Suffering through the withdrawal sickness is only part of the problem. The real difficulty has always been staying off the drugs once the period of withdrawal is over.

Just as in the case of those who are unable to stop smoking, it is difficult to explain why it is so hard not to return to the use of opioids. Reasons include long-term depression, lack of energy, drug cravings, and sudden attacks of physical withdrawal sickness. Some people find that these problems diminish over time and eventually disappear altogether – but others continue to suffer these symptoms indefinitely, and many of them eventually relapse to their regular use of opioids.

Relapse often has nothing to do with lack of will power or other personality problems. Instead, it appears that

people with a long history of opioid problems have experienced changes to the part of their brains that allows a person to feel and function normally. This part of the brain makes and uses its own natural opioids.

The best known of these natural opioids are the chemicals known as endorphins. The word endorphin literally means “the morphine within.” Indeed, these chemicals are functionally identical to morphine or heroin.

We don't yet understand everything that these natural opioids do in the body, but evidence suggests that they are involved with pain control, learning, regulating body temperature, and many other functions.

It is possible that people who develop a dependency on opioids were born with an endorphin system that makes them particularly vulnerable. For example, we know that addiction appears to run in some families.

Addiction might also be related to changes in the brain caused by the overuse of heroin or other opioids. Or it may be the result of a complex relationship between genetics and the environment. We do not yet know exactly how this malfunctioning occurs, or even whether all people who feel unable to stop using opioids have this damage. There is, however, an increasing amount of evidence that many people who find it difficult to end their use of opioids have experienced these physical changes – which are likely to be permanent.

There is not yet any test that can determine how much damage a person may have to his or her natural opioid system, or how hard it may be for that person to stay away from opioids. All that we know for sure right now is that relapse is a major feature of opioid dependency.

Methadone is not a cure for the problem of opioid dependency. It is a treatment – and one that is effective for only as long as a person continues to take it appropriately.

Relapse often has nothing to do with lack of will power or other personality problems.

What is Methadone?

Methadone is a long-acting, synthetic drug that was first used in the maintenance treatment of drug addiction in the United States in the 1960s. It is an opioid “agonist,” which means that it acts in a way that is similar to morphine and other narcotic medications.

When used in proper doses in maintenance treatment, methadone does not create euphoria, sedation, or an analgesic effect. Doses must be individually determined. The proper maintenance dose is the one at which the cravings stop, without creating the effects of euphoria or sedation.

Although methadone is not a single product from a single manufacturer, the active ingredient is always the same: methadone hydrochloride.



All manufacturers add inactive ingredients, such as fillers, preservatives and flavorings. Methadone is dispensed orally in different forms, which include:

- **Tablets**, also called diskettes. Each one contains 40 milligrams of methadone, is dissolved in water, and then is administered in an oral dose.
- **Powder** is also dissolved in water.
- **Liquid** methadone can be dispensed with an automated measuring pump. Dosages can be adjusted to as small as a single milligram.

Patients have different opinions about the various types of methadone. Each methadone provider usually offers a single type of the drug and obtains its supply from one source, which means that patients generally do not get to choose which form of methadone they get.

For most people, a single dose of methadone lasts 24 to 36 hours.

How is methadone different from heroin and other opioids (for example, morphine or dilaudid)?

Methadone lasts longer. The body metabolizes methadone differently than it does heroin or morphine. When a person takes methadone regularly, it builds up and is stored in the body, so it lasts even longer when used for maintenance. Most people find that once they're stabilized on a dose of methadone that's right for them, a single oral dose will "hold" them for at least a full 24-hour day. For some, the effect lasts longer; for others it lasts a shorter time.

Stability is easier on oral methadone. Most people who are on a stable, appropriate dose of methadone for several weeks will not feel any significant sense of being "high" or "dopesick." Some patients may feel a "transition" – or temporary, mild glow – for a short time several hours after being medicated, however. Others may feel slightly "dopesick" prior to taking the day's dose but most will feel very little or no effect from the proper dose of methadone once they have stabilized.

Buprenorphine

By Sharon Stancliff, MD

Buprenorphine, when appropriately prescribed and taken, is an effective, safe medication approved by the FDA for use in the treatment of opioid addiction. Buprenorphine relieves withdrawal, reduces craving and blocks the effects of heroin in ways similar to methadone. Maintenance doses are generally between 12 and 32 milligrams but (like methadone) should be individualized.

Unlike methadone, buprenorphine may be prescribed for treatment of opioid addiction by any doctor who has received training (available via the Internet or as a one-day course) and a waiver from the DEA. This is its principal advantage over methadone for most doctors and patients. Misuse of buprenorphine is less likely than methadone to result in death.

Prescribed in the U.S. as Suboxone or Subutex, buprenorphine is usually taken daily as tablets to be dissolved under the tongue. There is little effect from the drug if it is swallowed. Suboxone contains not just buprenorphine but also naloxone, an opioid antagonist that may precipitate withdrawal symptoms if injected. For people dependent on any opioid, taking the first dose of buprenorphine when not in withdrawal can result in acute withdrawal symptoms.

Buprenorphine, like methadone, can be used as a short- or long-term detoxification medication or indefinitely as a maintenance medication. The risks of relapse following detoxification appear to be similar whether methadone or buprenorphine (or any drug-free treatment modality) is used.

A directory of physicians approved to prescribe buprenorphine can be found at http://buprenorphine.samhsa.gov/bwns_locator/.

Maintenance

Methadone maintenance is intended to do three things for patients who participate:

1. Keep the patient from going into withdrawal. The standard initial dose, as currently recommended, is 30 to 40 milligrams a day. After several days, providers adjust a patient's dose as needed.

2. Keep the patient comfortable and free from craving street opioids.

Having a craving means more than just having a desire to get high. It means feeling such a strong need for opioids that people may have regular dreams about using drugs, think about doing drugs to the exclusion of anything else, and/or do things that they wouldn't normally do to get drugs.

Methadone won't control a person's emotional desire to get high, but an adequate dose of methadone should prevent the overwhelming physical need to use street opioids.

3. "Block" the effects of street opioids. If the dose is high enough, methadone keeps the patient from getting much, if any, effect from the usual doses of street opioids. This result is often called the "blockade" effect.

If a person's opioid tolerance is elevated high enough with methadone treatment, a great deal of heroin would be required to overcome it and produce a significant high.

Methadone won't control a person's desire to get high, but an adequate dose of methadone should **prevent the overwhelming physical need** to use street opioids.

After Methadone

Many people who must take medications every day get tired of doing so. This is especially true of patients on methadone maintenance because, in the United States, almost all methadone patients are also required to make frequent visits to a clinic to receive their medication. For many reasons, most methadone maintenance patients decide at some point that they want to stop taking methadone.

If you do choose to leave maintenance, your provider should reduce your dose at the speed you feel comfortable with. If it is slow enough you should not experience major physical withdrawal symptoms.

But if you have tried withdrawing from opioids many times and have relapsed, then you may have found that detoxing is the easier part and

staying opioid free over the long term is the harder challenge. Studies find that people who have long histories of trying and failing to live without opioids will probably not be able to stay abstinent for long.

It isn't yet possible to predict who will be able to live life without opioids, but it doesn't seem to depend on how "together" you are. If you are detoxing and find that you are craving opioids, or you have finished detoxing and you are always thinking of opioids, then perhaps maintenance should be part of your life.

Myths & Facts

Myth: Methadone gets into your bones and weakens them.

Fact: Methadone does not “get into the bones” or in any other way cause harm to the skeletal system. Although some methadone patients report having aches in their arms and legs, the discomfort is probably a mild withdrawal symptom and may be eased by adjusting the dose of methadone.

Also, some substances can cause more rapid metabolism of methadone (see pages 16-17 for a list of medications that interact with methadone). If you are taking another substance that is affecting the metabolism of your methadone, your doctor may need to adjust your methadone dose.

Myth: It’s harder to kick methadone than it is to kick a dope habit.

Fact: Stopping methadone use is different from kicking a heroin habit. Some people find it harder because the withdrawal lasts longer. Others say that although it lasts longer, it is milder than heroin withdrawal.

Myth: Taking methadone damages your body.

Fact: People have been taking methadone for more than 30 years, and there has been no evidence that long-term use causes any physical damage. Some people do suffer some side effects from methadone – such as constipation, increased sweating, and dry mouth – but these usually go away over time or with dose adjustments. Other effects, such as menstrual abnormalities and decreased sexual desire, have been reported by some patients but have not been clearly linked to methadone use.

Myth: Methadone is worse for your body than heroin.

Fact: Methadone is not worse for your body than heroin. Both heroin and methadone are nontoxic, yet both can be dangerous if taken in excess – but this is true of everything, from aspirin to food. Methadone is safer than street heroin because it is a legally prescribed medication and it is taken orally. Unregulated street drugs often contain many harmful additives that are used to “cut” the drug.

Myth: Methadone harms your liver.

Fact: The liver metabolizes (breaks down and processes) methadone, but methadone does not “harm” the liver. Methadone is actually much easier for the liver to metabolize than many other types of medications. People with hepatitis or with severe liver disease can take methadone safely.

Myth: Methadone is harmful to your immune system.

Fact: Methadone does not damage the immune system. In fact, several studies suggest that HIV-positive patients who are taking methadone are healthier and live longer than those drug users who are not on methadone.

Myth: Methadone causes people to use cocaine.

Fact: Methadone does not cause people to use cocaine. Many people who use cocaine started taking it before they started methadone maintenance treatment – and many stop using cocaine while they are on maintenance.

Myth: The lower the dose of methadone, the better.

Fact: Low doses will reduce withdrawal symptoms, but higher doses are needed to block the effect of heroin and – most important – to cut the craving for heroin. Most patients will need between 60 and 120 milligrams of methadone a day to stop using heroin. A few patients, however, will feel well with 5 to 10 milligrams; others will need hundreds of milligrams a day in order to feel comfortable. Ideally, patients should decide on their dose with the help of their physician, and without outside interference or limits.

Myth: Methadone causes drowsiness and sedation.

Fact: All people sometimes feel drowsy or tired. Patients on a stabilized dose of methadone will not feel any more drowsy or sedated than is normal.

Drug Interactions

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)
- Nevirapine (Viramune)
- Rifampin
- Efavirenz (Sustiva)
- Amprenavir (Agenerase) – methadone also significantly reduces the level of amprenavir.
- 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:

- 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.

For more information about drug interactions, go to:

www.hivguidelines.org.

Search under "methadone."

If your methadone dosage doesn't feel right, it probably isn't right.

Your Other Doctors

Methadone patients are sometimes reluctant to tell their other doctors that they are taking methadone. They are afraid that these doctors – or other health-care providers – will discriminate against them. Unfortunately, they are often right.

Find a primary-care provider whom you can trust. The ideal situation is to make sure all your doctors know that you are taking methadone. If you choose not to tell them, however, keep these important things in mind:

- If you are having surgery for which you may be put to sleep, the anesthesiologist might use a type of medication that will cause abrupt methadone withdrawal. Be sure you know which medications interact with methadone (see pages 16-17) – even if your doctors know that you are taking methadone.
- It is illegal for your methadone provider to communicate with your primary-care doctor or anyone else without your written permission. (Title 42 of the Code of Federal Regulations Part 2 [42CFR part 2] protects against disclosure of drug treatment records.)



Ideally, though, open communication among all the doctors who are treating you may assist you in getting the best possible health care.

Methadone & Women

Is it true that women sometimes stop getting their periods when they begin taking methadone?

Yes, but there are also many other reasons why women's periods become irregular or stop:

- Pregnancy
- Stress
- Poor diet
- Weight gain and loss
- Menopause
- Other medical problems
- Other medications

Remember:

- You can still get pregnant even if you don't get your period.
- You can conceive and have normal pregnancies and normal deliveries while you are receiving methadone.

You may have heard that you should not take methadone when pregnant. This is not true.

- Methadone is not harmful to the developing fetus – but detoxing is.
- Methadone is the treatment of choice for heroin and opioid dependency during pregnancy.
- The effects of methadone on pregnancy have been widely studied.
- Methadone has been used successfully during pregnancy.
- When properly prescribed for pregnant women, methadone provides a non-stressful environment in which the fetus can develop.
- Taking methadone during pregnancy may prevent miscarriage, fetal distress, and premature labor.
- Decreasing the dose of methadone during the first trimester increases the risk of miscarriage.
- During pregnancy, your dose should be sufficient to avoid cravings, avoid street drugs, and prevent withdrawal.

Methadone & Women (cont.)

If you are pregnant, be sure to talk with your doctor, because:

- When you're pregnant, your body metabolism changes, so you may need to adjust your dosage. You may need to increase your dose of methadone, or split your dose and take smaller amounts two or three times a day.

You may have heard that your baby will be born addicted to methadone or will suffer other side effects, but here are the facts:

- Methadone does not cause fetal abnormalities. No harmful effects to a fetus have been found in the study of methadone's effect on pregnancy.
- Premature birth and low birth weight can be associated with cigarette smoking and/or poor nutrition and are not attributed to methadone.

- Babies born to mothers dependent on methadone will have methadone in their systems, but studies show that the children can be weaned successfully and safely with no adverse effects.

You may have heard that you shouldn't breast-feed your baby if you are taking methadone, but here are the facts:

- Breast-feeding is now considered safe for the babies of women who are taking methadone, but not safe for women who are HIV positive.
- Small amounts of methadone in breast milk can pass to the baby.
- Methadone levels in breast milk are very low.

Storing Methadone

While at home, always keep your methadone in a safe place – preferably in a locked box or cabinet – **out of the reach of children** and **clearly marked** to prevent anyone else from taking it accidentally.

Remember: Methadone is a very strong drug. A small amount can kill a child or an adult who does not have a tolerance to it. If anyone in your home accidentally drinks your methadone, call 911 or an ambulance immediately.

Store your methadone away from extreme heat or cold. The methadone that you take home is often mixed with water – and sometimes mixed with other additives, depending on where you get your methadone. The solution typically lasts for weeks.

When you are traveling or away from home, keep your methadone in the prescription bottles that were given to you by your methadone provider to prevent any trouble with the law. As with any prescription drug, it is illegal to possess methadone without a prescription.

If anyone in your home accidentally drinks methadone, call 911 or an ambulance immediately.

Concerns About Overdose



Methadone treatment reduces the chance of overdose for those who are using or are addicted to heroin.

Methadone is a pure drug and is individually prescribed. It does not contain the harmful “cuts” that are mixed into drugs bought on the street. Concerns about overdose remain, however, especially if you continue to use street drugs or if you resume regular heroin use after stopping your methadone treatment.

If you stop taking methadone and start using street drugs again, your chance of overdose increases because you now have a lower tolerance for the drugs. Tolerance increases when your body has gotten used to having the drug in its system – in other words, your body “tolerates” the presence of the drug. If you stop using regularly – or if you have detoxed – it takes a smaller amount of the heroin, methadone, or other opioid to cause an overdose. Also, mixing pills such as benzodiazepines, barbiturates and/or alcohol with methadone or heroin increases the risk of overdose.

Frequently Asked Questions

Can I overdose on methadone?

It is possible to overdose on methadone, but providers work to adjust dosages so that they are safe for each individual patient. It is important to be honest with the clinic staff about how much heroin or other opioids you are using so that they prescribe a dosage that is right for you – too little won't be effective; too much could cause you to overdose. Methadone is a strong medication, so you need to build up the dosage slowly to be sure that your body is handling the medicine well.

Can I overdose on buprenorphine?

Misuse of buprenorphine is less likely than methadone to result in death (see page 10).

What if I use other drugs while I am taking methadone?

The correct dosage of methadone blocks the effects of heroin. If you take opioids while also taking methadone, you may not feel the effects of the opioids. You may then decide to take even more of the opioid, which could cause an overdose. Some drugs also interact with methadone and can change how your medications affect you (see pages 16-17). Taking too much of a sedative or drinking a lot of alcohol while you are taking methadone can also be dangerous because each substance makes the other more powerful, increasing your risk of overdose. Be extremely careful if you mix these drugs.

The correct dosage of methadone blocks the effects of heroin.

Concerns About Overdose (cont.)

Can I overdose on heroin while I am taking methadone?

Yes. Even while taking methadone, if you take too much heroin – especially if the heroin is unusually strong – you could overdose. You increase the odds of overdosing on heroin while you're taking methadone if you mix it with sedatives, alcohol, or other drugs.

What if I stop going to my methadone program?

If you stop taking your methadone and return to using street drugs, you can overdose more easily than when you last used. When you stop taking methadone, your body will rapidly develop a lower tolerance for the heroin. As soon as your methadone completely wears off (a couple of days), your tolerance for heroin will be lower than it was when you began taking methadone. So, if you decide to use again, you need to be

very careful. Take some precautions – always be sure there are other people with you when you're using, in case you need medical attention, and test the effect of the drug on you before you take an entire dose.

What happens if I start taking methadone again after I have stopped?

If you stop taking methadone even for a few days, you need to be careful when you start taking it again. Your body may have lost some of its tolerance for the methadone, so you could overdose. You need to restart at a lower dose and work back up to the level you were at when you stopped. The doctor at the clinic can help you determine the right dosages.

In Case of Overdose

If you suspect that someone has overdosed on methadone, lay the person on his or her side in the recovery position and call 911 immediately.

If medical professionals arrive quickly, they can treat the individual with an antagonist, such as naloxone, that will help them come out of the overdose. It is important to tell the medical professionals what drug the overdose victim took so they know which drug to use to counteract the overdose.

The person who overdosed will need to be watched for a few hours. Methadone is a long-acting drug. The medications that are used to treat the overdose are short-acting. If the antagonist wears off before the methadone level decreases enough, the patient may go back into a state of overdose and require medical attention again.

What should I do if someone overdoses?

- Immediately call 911 and remain with the person.
- Do not force the person to vomit.
- Do not make them take a cold shower.
- Do not inject salt water into their veins.

What are the signs of an opioid overdose?

- Unresponsiveness
- Drowsiness
- Cold, clammy, bluish skin
- Reduced heart rate
- Reduced body temperature
- Slow or no breathing

What might happen if an overdose is not treated?

- Brain damage
- Paralysis (temporary or permanent)
- Death

Detoxification

Doctors do not advise that people quickly taper off of their dose of methadone – but there are, unfortunately, many situations where this occurs. For example, a methadone patient may be in jail or in a hospital where methadone is not prescribed. Or the person may be complying with a demand from family court in order to be reunited with children who are in foster care. Public policy is slowly changing, but some methadone patients are still being forced to detox from their medication.

If you are being “administratively detoxed” by your methadone provider, you should find another provider quickly. If your provider is not helping you find another, contact a harm reduction program, needle exchange, or your state’s health department for assistance. A directory of state alcohol and drug abuse agencies can be found at www.treatment.org/states/index.html

Some people also use gradually tapering doses of methadone for a short period of time (three to seven days) to relieve the initial discomfort

of heroin withdrawal. This method may be successful for people who haven’t been dependent on heroin or other opioids for a long time.

If you do start using drugs again after your detox, you are not a “failure.” Time that you spent away from street drugs was a period of reduced risk – risk of arrest, exposure to disease, and overdose. But remember, if you relapse, the first weeks of use (again) are a time of higher risk of overdose.

How it Works

Methadone patients have two options: inpatient and outpatient treatment.

With inpatient treatment, the patient is admitted for overnight care to a clinic or hospital. The patient usually must spend several days and take medication to relieve the withdrawal symptoms. In outpatient detox, medication also provides relief from withdrawal symptoms. The medication is administered during daily clinic visits over a period of several weeks or longer. Often methadone is used in doses that are gradually reduced.



Any “cross-tolerant” opioid – such as morphine, dilaudid, methadone, heroin, or LAAM – can suppress withdrawal. Methadone is used because it is long-acting, gentle, eliminates craving, and does not produce a “high” when it is used properly.

Other medications, including drugs such as buprenorphine and clonidine, are also used – and may be used more widely in the future.

The usual detox program for methadone requires that the patient use it as a tapering dose for 21 to 30 days. During induction, the doctor determines the right dose to overcome withdrawal. Afterward, the dose you take gradually becomes smaller, until you no longer need the methadone. The medical and counseling staff in your program can help you develop a plan for further treatment if you need it, and will guide you through the physical changes you experience during the detox period.

Methadone & Pain

Severe pain has long been under treated in the United States. This is partly because of ignorance and prejudice, but also because of the laws that made drugs like heroin illegal. The government has actively pursued and prosecuted physicians for prescribing opioids.

If you are on methadone maintenance, your regular maintenance dose of methadone will provide little or no pain relief. You will still feel pain, just like everyone else. In fact, you may need more pain-relief medication than people who are not taking methadone.

Greater public awareness of how many people have needlessly suffered because of this undertreatment of pain is beginning to force changes. To manage pain, doctors are beginning to more freely prescribe opioids – including methadone, which has been recognized as an effective pain medication.

Driving

Study after study has shown that people who are maintained on a correct dose of methadone can do anything that people who are not using any medication can do.

Researchers have conducted laboratory and field studies since 1964. They have consistently found that methadone – when used in the treatment of heroin addiction – has no adverse effects on a person’s ability to think and function normally.

Methadone patients still experience a great deal of discrimination by employers, however, especially when they seek to get or keep jobs that involve driving.

Discrimination persists, despite the fact that people maintained on methadone are no different from the general population in their motor skills, reaction times, ability to learn, focus, and make complex judgments.

Of course, your ability to think and function normally depends on your having the correct dosage of methadone. If you feel groggy, tired, or unable to focus, you should not drive. Be sure to consult your clinician about whether you are receiving a correct amount of methadone.



Traveling with Methadone

Traveling in the United States

It can be very stressful for methadone patients to plan a trip. Rules vary from place to place throughout the United States, and many of them are unclear.

If you are traveling within the United States, decide whether you want to travel with your medication or obtain it when you arrive at your destination.

To be sure that your methadone treatment is not interrupted, you will either need to get enough methadone from your provider to cover you for the entire time you're away – or your provider/clinic will need to arrange for you to be “guest medicated” at a methadone clinic located in the area where you will be staying.

In either case, it is wise to make your arrangements as early as possible before you leave.

Keep in mind that federal, state, and clinic regulations limit the amount of methadone that you can take with you. These rules differ from place to place, so check with your provider to find out about the rules in the areas you plan to visit.

A comprehensive “Methadone Maintenance Treatment Directory” listing contact information for outpatient methadone maintenance facilities in the United States can be found on the Internet at:

www.findtreatment.samhsa.gov.

If you do not have access to the Internet, see the directory of state substance abuse agencies on page 32.

Traveling Abroad

Methadone is a prescribed medication, and most countries allow visitors to bring whatever prescription medications they need with them. In some places, however, methadone may be considered an exception to this policy.

In many countries, methadone is not available, and some countries prohibit bringing it in. Some countries also have laws prohibiting former addicts or people with criminal records from entering. It may be difficult to find out which laws are in effect in which countries – and which laws are actually enforced.

There are some resources that patients can check to determine the laws that apply to methadone at their destinations. Ultimately, however, patients are responsible for determining whether it is legal and/or safe to bring methadone with them when they travel.

- An excellent place to start is the INDRO Web site at: www.indro-online.de/travel.htm
- For more information about European methadone providers, go to: www.q4q.nl/methwork2/home.htm
- You can also check with the consulate of the country that you are traveling to – although not all consulates will be well informed about methadone.

Whichever country you travel to, you will need to decide whether you will carry your own methadone (where permitted) or find a methadone provider there who will treat you (if one is available).

Whichever option you choose, you will need to bring your prescription for methadone, and, if you are guest-medicating, a letter from your home provider, explaining your prescription/dosage. Make these arrangements as early as possible before your trip.

What should you do if methadone importation is prohibited at your destination?

Knowing that their medication is legal, most simply do not declare it at customs unless they are specifically asked to do so. There are, however, severe penalties for importation of even small, prescribed amounts of medications in some countries (for example, the death penalty in Singapore!).

Each patient will have to weigh this decision very carefully. Many methadone patients have traveled to various parts of the world without experiencing any problems.

State Substance Abuse Agencies

Alabama	334.242.3961	Nebraska	402.471.7818
Alaska	907.465.2071	Nevada	775.684.4190
Arizona	602.542.1000	New Hampshire	603.271.6110
Arkansas	501.686.9866	New Jersey	609.292.5760
California	800.879.2772	New Mexico	505.827.2601
Colorado	303.866.7480	New York	518.473.3460
Connecticut	860.418.7000	North Carolina	919.733.4670
Delaware	302.255.9399	North Dakota	701.328.8920
District of Columbia	202.727.8857	Ohio	614.466.3445
Florida	850.487.2920	Oklahoma	405.522.3619
Georgia	404.657.2331	Oregon	503.945.5763
Hawaii	808.692.7506	Pennsylvania	717.783.8200
Idaho	208.334.5935	Puerto Rico	787.764.3795
Illinois	800.843.6154	Rhode Island	401.462.4680
Indiana	317.232.7800	South Carolina	803.896.5555
Iowa	515.281.4417	South Dakota	605.773.3123
Kansas	785.296.6807	Tennessee	615.741.1921
Kentucky	502.564.2880	Texas	512.206.5000
Louisiana	225.342.6717	Utah	801.538.3939
Maine	800.499.0027	Vermont	802.651.1550
Maryland	410.402.8600	Virginia	804.786.3906
Massachusetts	617.624.5111	Washington	877.301.4557
Michigan	517.335.0278	West Virginia	304.558.2276
Minnesota	651.582.1832	Wisconsin	608.266.2717
Mississippi	877.210.8513	Wyoming	307.777.6494
Missouri	573.751.4942		
Montana	406.444.3964		

Other Resources

For more information about methadone, please visit:

Addiction Treatment Forum
www.atforum.com

The Baron Edmond de Rothschild Chemical Dependency Institute
www.opiateaddictionrx.info

Centers for Disease Control
www.cdc.gov/idu/facts/Methadone.htm

Drug Policy Alliance
www.drugpolicy.org/library/research/methadone.cfm

The National Alliance of Methadone Advocates
www.methadone.org

Substance Abuse and Mental Health Services Administration
<http://csat.samhsa.gov/publications/PDFs/brochure.pdf>

For information about buprenorphine, please visit:

Substance Abuse and Mental Health Services Administration
<http://buprenorphine.samhsa.gov>

The National Alliance of Advocates for Buprenorphine Treatment
www.naabt.org

The Drug Policy Alliance published *About Methadone and Buprenorphine* to help patients make healthy and informed treatment decisions with their doctors. As part of our broader mission, we also seek to end the prejudices and policies that cause discrimination against all people in maintenance therapies.

By educating hundreds of thousands of readers, *About Methadone and Buprenorphine* has helped advance both of these goals, so we're pleased to offer it for just the cost of production. As a private, nonprofit organization, however, the Drug Policy Alliance relies solely on our members and contributors for financial support – both to advance drug policies based on science, health, compassion and human rights, and to aid in the distribution of *About Methadone and Buprenorphine* and publications like it.

Please join our fight for the rights and dignity of methadone patients and the millions of others who suffer the consequences of the failed war on drugs. Join the Drug Policy Alliance today.

To become a member and help end the war on drugs, please contact:

Membership
Drug Policy Alliance
70 West 36th Street
16th floor
New York, NY 10018
212.613.8020 voice
212.613.8021 fax
membership@drugpolicy.org
www.drugpolicy.org/join

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