Safety during MMT startup can be maximized by careful prescribing, close monitoring, & patient education.

**Practice Pointers**

**Safely Starting Methadone in MMT**

Recently, in the *Journal of Addictive Diseases*, two Canadian clinicians – Anita Srivastava, MD, and Meldon Kahan, MD [1] – reviewed the literature on methadone-related deaths during the induction phase of methadone maintenance treatment (MMT) for opioid addiction, examined current dosing guidelines, and made recommendations for improving patient safety. They described how safety during MMT startup can be maximized through careful prescribing, close monitoring, and patient education.

**Risk Factors to Consider**

According to Srivastava and Kahan, despite its successes as a treatment for opioid addiction, there are a significant number of deaths among MMT patients. While such deaths are tragic in themselves, they also have serious consequences for the continuation and expansion of MMT programs.

Newspaper headlines touting the dangers of methadone can do enormous harm to programs by disrupting patient access, and damaging community and government support. Thus, effective guidelines must balance the concerns of overdose deaths, public safety, treatment retention, and program survival.

The majority of deaths occur during the initial phases of MMT. Srivastava and Kahan describe a number of factors that may be involved:

1. Methadone can accumulate rapidly and unpredictably in the blood serum, in part due to variable individual

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**Clinical Concepts**

**Notes from ASAM’s “Pain & Addiction” Course**

Late last October, the American Society of Addiction Medicine (ASAM) launched the 7th generation of its popular 1-day seminar, “Pain & Addiction: Common Threads.” A new faculty of 11 presenters, led by co-chairs – Donald Kurth, MD, FASAM, and Herbert Malinoff, MD, FACP, FASAM – conducted an intensive program attended by about 125 healthcare professionals.

Following are some notes from the day’s lectures and case studies.

**Doing Opioid Analgesia “Right”**

Jennifer Schneider, MD, a pain practitioner from Arizona, discussed opioid therapy for chronic pain, which might be defined as pain that no longer serves as a physiological warning sign and persists for 3 to 6 months or much longer. It is a multifaceted experience, also negatively affecting emotions, thinking, memory, and other aspects of the patient’s functioning.

Chronic pain management includes using medications to decrease pain and increase function. However, medications are but one part of an overall approach, which may also include physical therapy, acupuncture, massage, hypnosis, and other modalities.

Schneider observed that there are many barriers to the use of opioid analgesics, and most involve fear on the parts of prescribers and patients. Prescribers may be concerned about opioid toxicity, causing or worsening addiction, being “scammed” by patients, and regulatory.

Continued on page 4
Events to Note

For additional postings, including international meetings, see: www.atforum.com

February 2007
Community Anti-Drug Coalitions of America (CADCA) National Leadership Forum
February 12-15, 2007
Washington, DC
Contact: 800-54-cadca or www.cadca.org

March 2007
Medical and Scientific Conference on Addictions - Fla. Soc. Addiction Med. (FSAM)
March 1-4, 2007
Gainesville, Florida
Contact: John Harden at (866) 853-2524 or www.fsamonline.org

National Drug Treatment Conference
March 15-16, 2007
London, UK
Contact: http://www.exchangesupplies.org/conferences/conferences.html

Soc. of Behavioral Med. 28th Annual Meeting
March 21-24, 2007
Washington, DC
Contact: 414-918-3156 or http://www.sbm.org/meeting/2007/

Amer. Counseling Assoc. Convention
March 21-25, 2007
Detroit, Michigan
Contact: 800-347-6647 or http://www.counseling.org/Convention/About/TP/Home/CT2.aspx

1st Annual Conference of the International Society for the Study of Drug Policy
March 22-23, 2007
Oslo, Norway
Contact: http://www.issdp.org/conferences.htm

Later 2007
ASAM 38th Annual Meeting & Medical-Scientific Conference
April 27-29, 2007
Miami, Florida
Contact: 301-656-3920 or www.ASAM.org

7th International Conference on Pain & Chemical Dependency
June 21-24, 2007
New York City, New York
Contact: 1-800-370-9293 or http://www.iapcd.com/

AATOD (American Association for the Treatment of Opioid Dependence) Conference
October 20-24, 2007
San Diego, California
Contact:212-566-5555 or http://www.aatod.org

[To post your event announcement in AT Forum and/or our website, fax the information to: 847-392-3937 or submit it via e-mail from www.atforum.com]

Straight Talk... from the Editor

Addiction Myths Keep Spreading Nonsense

Persistent myths about what addiction is or isn’t, and how it should or shouldn’t be treated, have a capacity to distort public opinion and do great harm. AT Forum discussed this 5 years ago, when we wrote of Stanton Peele’s assertions that “addiction is nothing more than a way of coping with life...,” and most people simply outgrow their addictions (Spring 2001, Vol. 10, No. 2).

Now, along comes the latest incarnation of this addiction mythology in a book titled Romancing Opiates: Pharmacological Lies and the Addiction Bureaucracy by Theodore Dalrymple. Among other allegations, this author (actually a British prison doctor writing under a fictitious name) claims that opioid addiction is a moral problem, opioid withdrawal effects are trivial, and addicts do not need medical help to stop taking drugs.

Poppycock!!

Such claims — throwbacks to 19th Century beliefs — would be harmless exercises in freedom of speech were it not for the fact that people do purchase the books of these critics. And, newspapers publish their articles, such as Dalrymple’s essay, “Poppycock,” in the Wall Street Journal last May.

He suggests that all opioid addicts fake their withdrawal symptoms. “I have witnessed thousands of addicts withdraw; and, notwithstanding the histrionic displays of suffering... I have never had any reason to fear for their safety.”

He continues, “When, unbeknownst to them, I have observed addicts before they entered my office, they were cheerful; in my office, they doubled up in pain... threatening suicide unless I gave them what they wanted. When refused... a few laughed and confessed that it had been worth a try.”

“It is not true either that addicts cannot give up without the help of an apparatus of medical and paramedical care,” he alleges. “In China, millions of Chinese addicts gave up with only minimal help: Mao Tse-Tung’s credible offer to shoot them if they did not. There is thus no question that Mao was the greatest drug-addiction therapist in history.”

Pharmacohegemony?!

More recently, in an online debate last October (2006) hosted by FrontPage-Magazine.com, Dalrymple said that medical treatment for addiction “often does tangible harm... by persuading addicts that they ‘need’ the help of professionals to stop. This, of course, is all to the advantage of a group of professionals.”

As if agreeing, an addiction-treatment provider on the panel, who should have known better, claimed that the treatment of addiction with medications like methadone or buprenorphine “is based on an unproven and phony theory that opioid addiction causes irreversible ‘metabolic lesions’ that can only be treated with replacement therapy. ... This acceptance of replacement therapy is so well-entrenched and the use of methadone so widespread that I call this ‘pharmacohegemony.’”

Thus, using a fancy made-up term, he blatantly dismissed decades of scientific research supporting the benefits of medication-assisted addiction treatment.

Evil Ancestors?!

Then, just when we thought we had heard it all, last November (2006) there was a press release from the Spiritual Science Research Foundation (SSRF) in Australia. They claim 96% of all addictions are “caused due to possession by either ghosts or our departed ancestors.”

“The absurdity of proclaiming as effective “therapy” the inhumane schemes of a communist tyrant speaks for itself. Indeed, Dalrymple’s prejudiced perspectives without a shred of credible clinical evidence to support them might be the true poppycock, or senseless talk, in all of this.”

Continued on page 3
A Voice of Reason...

A lone voice of reason came during the FrontPageMagazine.com debate noted above from a person in recovery from opioid addiction: "There are no perfect solutions for drug treatment but to deny any and all successes that have been made so far or to say that the whole rationale of treatment is flawed is irresponsible – especially when no alternative is suggested. It takes no courage to criticize an imperfect approach."

"Those who have not suffered from addiction tend to suggest simplistic non-tolerant, holier than thou approaches. Additionally, the constant belittling of addicts and treating them as less than human makes many of the critics of current treatment options, just that – critics – but they fail to make any real contributions or humane suggestions of dealing with the problem," he said.

Meanwhile, there is the nagging question of what patients and professionals in the addiction treatment field can or should do about those critics. We encourage readers to participate in our survey on this subject in this edition (see below).

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NEW SURVEY: Fighting Myths?

As a followup to the editorial in this issue, please respond to the following survey questions:

1. What do you believe MMT staff or patients should do about addiction myths in the media? Q Write complaint letters to publishers and news editors; Q Boycott news media that spread myths; Q Protest to political leaders; Q Do nothing; or Q Other __________________________.  
2. Besides ‘nothing,’ have you ever done any of the above? Q Yes; Q No.  
3. If so, what did you do? (specify)  
4. Are you responding as Q an MMT patient, or Q MMT clinic staff member or other?  

There are several ways to respond to AT Forum surveys: A. provide your answers on the postage-free feedback card in this issue; B. write, fax, or e-mail [info above]; or, C. visit our website to respond online. As always, your written comments are important.
consequences in how patients are treated.

In actuality, these patients may be reacting to pain that has been undertreated or mistreated. [See Survey Results in this edition of AT Forum; page 8.] Rather than CPS, the presumed aberrant behaviors might reflect patients’ dealings with a healthcare system that has been unresponsive to their needs, resulting in frustration, anger, and other problems.

"Hedonic Tone" Connection

To complete the day, Edwin Salsitz, MD, FASAM, from Beth Israel Medical Center, New York, presented his interesting concept of the relationship between pain, addiction, and hedonic tone. The term "hedonic" relates to one’s sense of pleasure. Good hedonic tone provides a sense of well being, happiness, and contentment. Conversely, poor hedonic tone deprives the person of a sense of joy, comfort, or satisfaction.

Anatomical centers of hedonic tone in the human brain encompass both the circuits for pleasure that drive addiction and those that process and interpret pain sensations. Technically, this is called the "mesolimbic" area.

Salsitz proposes that some persons have inherently low hedonic tone and they find that certain addictive substances raise the level to where they feel more ‘normal’ or comfortable. Along those lines, chronic pain can lower whatever natural hedonic tone the person might have, until their pain becomes a daily struggle with torment and suffering.

For these reasons, treating persons experiencing both addiction and chronic pain can be challenging. Salsitz suggests that the complex actions and interactions of medications used to treat each condition can be difficult to anticipate and manage. Furthermore, as suggested above, the recovery process for both pain and addiction requires attention to physical, psychosocial, spiritual, and other life factors.

Although, this approach proposed by Salsitz is somewhat theoretical and further research would be appropriate, there is support in the neurobiological literature. And, it takes into account the necessity of a holistic approach to patient care, which may be more compassionate and effective in the long run.

The next ASAM-sponsored “Pain & Addiction: Common Threads” course will be April 26, 2007 in Miami, Florida. For information see http://www.asam.org, or call 301-656-3815.

The authors concede that the relative risk of death at different starting or increment doses of methadone is not known, either for the medication alone or when combined with other drugs. Nonetheless, they note, the literature suggests that methadone is a potentially dangerous drug with a narrow margin of safety during the initial titration.

Srivastava and Kahan state that the ratio between a potentially fatal single startup methadone dose of 50-70 mg and a maximum-recommended initial methadone dose of 30 mg is approximately 2:1. As comparative examples, the lethal-to-therapeutic ratios for phenytoin, acetylminophen, and desipramine are 6:1, and 10:1 and 20:1, respectively. Thus, methadone has a relatively narrow safety margin for overdose compared with some other medications. [However, accurately defining the lethal dose of methadone is difficult – see Box on page 7.]

While caution is necessary with methadone induction doses, the authors recommend that this must be balanced against treatment needs. Higher methadone doses have been shown to reduce opioid use and increase treatment retention. A lower initial dose will extend the time required to reach the optimal dose by 1 to 2 weeks, prolong the patient’s substance abuse, and increase the risk of overdose. Finally, early weeks of MMT often are associated with high dropout rates, and lower starting doses may have a further negative influence.

Therefore, methadone induction-dosing protocols should balance risks and benefits, considering not only methadone deaths but also treatment retention and achieving illicit opioid abstinence as quickly as possible.

Suggested Guidelines

Taking into consideration the limited evidence on methadone-related deaths, Srivastava and Kahan developed guidelines that they believe: A) incorporate the best available evidence to date, B) balance the need for safety with the need to retain patients in treatment, and C) allow for the reality that many patients use other substances that could contribute to fatal overdoses in combination with methadone.

The authors reviewed methadone-
Starting Methadone... cont. from page 4

induction dosing guidelines from the U.S., Canada, Britain, Australia, and other countries. Recommended first-day starting doses ranged widely between 10 mg up to 40 mg, depending on estimated opioid tolerance in the patient. Two countries (Ireland and Spain) allowed first-day dosing up to 60 mg.

U.S. Federal regulations recommend a maximum first dose in patients actively abusing opioids of up to 30 mg methadone.[2,3] If withdrawal symptoms persist at 2-4 hours, an additional 5-10 mg is allowed, but the total first-day methadone dose cannot exceed 40 mg unless the program physician specifically documents the necessity for more.[2, also see Box on page 7]

In general, Srivastava and Kahan [1] recommend an initial methadone dose of no more than 30 mg, or 10-20 mg for high-risk patients. Dose increases should be no more than 5-15 mg every 3 to 5 days, with a total weekly increase of no more than 20 mg for high-risk patients. Any increases in the 10-15 mg range should be only for patients who remain in withdrawal for much or most of the day. See the Table, and the authors’ notes as follows:

**Defining "Higher Risk"**

High-risk patients include those over age 65, those with underlying respiratory disease or severe hepatic dysfunction, and those taking cytochrome P450 inhibitors (such as quinolone or macrolide antibiotics, fluconazole, and some SSRIs). Also at high risk are patients on any sedating medication, including benzodiazepines, antidepressants, sedating antihistamines, and antipsychotics. Patients who might have a lower baseline opioid tolerance are also at high risk.

**Lower Opioid Tolerance**

Lower tolerance might be expected in patients who do not use opioids daily or who are taking oral opioids at ‘moderately high’ doses (e.g., codeine, or less than 200 mg of oral morphine or its equivalent). Establishing opioid use can be difficult; patients might exaggerate their use to get on methadone, or they simply may not remember how much they take day to day.

The reliability of a tolerance estimate might be aided by obtaining corroborating information from other physicians or family members, and by confirmation of opioid use through high-precision urine drug testing. If there is doubt regarding the patient’s level of tolerance, it is safer to use the lower initial dose.

**Special Precautions**

To help avoid methadone-drug interactions, patients should be advised to check with MMT staff prior to taking any newly prescribed medications. [For current tables of potentially interacting substances see: http://www.atforum.com/SiteRoot/pages/addiction_resources/Drug_Interactions.pdf]

Sedating drugs should not be prescribed unless the patient has already been on a moderate dose of those medications daily for at least 2 months and the clinician is confident the patient is compliant. Such patients should receive lower initial methadone doses. Patients dependent on high daily doses of street benzodiazepines should be tapered off of them, preferably in an inpatient setting, before initiating methadone.

Patients who binge on alcohol or benzodiazepines are perhaps the most difficult group to manage. It might be necessary to assess and observe such patients before and several hours after each methadone dose, particularly on the 3rd or 4th day after a dose increase. Methadone titration on an inpatient basis should be considered, if available.

**Take-Home Doses**

The patient should not be given take-home bottles of methadone during the initial titration, even if family members agree to dispense it. In fact, this can lead to problems including the dangerous possibility that family members may dispense the medication incorrectly, divert it, or use it for personal consumption. [In the U.S., this could mean that startup dosing should not be initiated close to a Sunday or holiday when the clinic will be closed and a take home dose allowed.]

**Monitoring**

The patient should be assessed by the clinic physician at least twice per week, preferably several hours after the patient’s dose. Within the bounds of confidentiality, a patient’s family members or significant others should be asked to report on the patient’s response to methadone. Patients and, ideally, their families or significant others should be alerted to symptoms of overdose, and told to contact the clinic or emergency services at the first sign of toxicity. Higher-risk patients may require very close monitoring.

**Missed Doses**

Patients who miss a dose during the initial titration period may lose some tolerance to methadone, and their current dose should be extended without increase for 1 or 2 days. Titration should be restarted at the initial dose if 2 consecutive doses are missed.

**Patient Education**

The patient should be advised to take methadone in morning, avoid alcohol, sedating drugs, and triggers. Have family member call clinic or emergency number at first sign of toxicity. Do not take substances to relieve withdrawal symptoms; however, if you do, take 10 hours after last methadone dose. Check with a physician before discontinuation or initiation of any medications.

*U.S. Federal Regulations allow for 1 take-home dose if clinic is closed on Sunday or a holiday.[2,3]

Adapted from Srivastava and Kahan 2006.[1]

**Table**

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Continued on page 7
New Book Aids Understanding of MMT

Among the many articles, pamphlets, and booklets of all sorts seeking to explain how methadone maintenance treatment (MMT) really works, this book stands out most favorably. *Professional Perspectives on Addiction Medicine: Understanding Opioid Addiction and the Function of Methadone Treatment* is a long title for a rather brief and compact book (120 pages, 5” x 8”) that is authoritative, comprehensive, and very easy to read.

Edited by two experienced practitioners in the field – Mark Stanford, PhD, and Donald Avoy, MD – authors of the book’s 8 chapters include such well-known clinicians as Joan Zweben, PhD, Judith Martin, MD, Robert Kahn, PhD, and others. The document was developed under the auspices of the Santa Clara Valley Health & Hospital System, Department of Alcohol & Drug Services (DADS), San Jose, CA.

As a bonus, the book can be downloaded as a PDF document free of charge at ATForum.com or printed copies can be ordered at a nominal charge. See instructions below.

Widespread Appeal

We agree with the editors that, “It’s not difficult to obtain a variety of opinions about methadone… and many of them would be quite negative and unfounded.” Their expectation for this new book – published in 2006, but just recently updated in November 2006 – is to promote increased awareness about MMT, its foundation in evidence-based science, and its effectiveness in treating opioid addiction.

While the editors suggest the book would be particularly important for persons outside the methadone treatment field, we believe it has importance for everyone with an interest in the treatment of opioid addiction. It definitely should be read by all MMT clinic staff and they should strongly recommend it to community leaders, law enforcement personnel, educators, and others. Many current or prospective MMT patients, and their loved ones, also could benefit.

Authoritative Yet Accessible

The text is easy to follow and all medical terms are clearly defined, so readers without medical training will find the book understandable. Yet, the authors do not shy away from what otherwise could be overly complex subjects.

Exemplifying this approach is the title of Chapter 3 written by Stanford: “The Behavioral Pharmacology of Methadone: The Easy-to-Understand Version.” This is an important subject, which would be off-putting for some readers were it not for Stanford’s clear explanations using everyday language.

Stanford introduces the ironic appeal of heroin with a quote from actor Robert Downy, Jr., “Heroin addiction: It’s like I’ve got a shotgun in my mouth, my finger’s on the trigger and I like the taste of gun metal.” Stanford continues in a mere 15 pages to clearly explain how opioids in general work in the brain and how methadone, at an optimally adequate dose, serves to stabilize brain function that has run amok.

Like all chapters in the book, this one is based on scientific evidence and references for relevant literature are provided. In fact, the ample references to authoritative resources consulted in developing the book set it apart from most other literature of this type intended for a broad audience.

Other chapters cover such subjects as outcomes of MMT, effects of co-occurring mental health issues, methadone and pregnancy, and more. A final chapter explores myths, misunderstandings, and stigma surrounding methadone. There also is a very well-written perspective from a patient who tried every other treatment imaginable before finding that MMT really does work best for a great many persons seeking addiction recovery.

How to get a copy...


Text Sheds Light on Psychopharmacology

Unquestionably, a large number of patients coming into methadone maintenance treatment (MMT) programs today have co-occurring mental or psychological disorders of some sort. And, most of those persons are already taking or will be prescribed medications for those afflictions, an aspect of medicine called “psychopharmacology.”

Therefore, a new book – *Psychopharmacology Handbook for the Non-Medically Trained* – serves a vital need for MMT clinic staff who would benefit from a better understanding of those medications.

As the title implies, this 270-page text could be invaluable for MMT clinic staff who might be considered non-medically trained: counselors, therapists, social workers, and others who have patient contact. These persons need to understand the variety of medications patients may be taking, their actions, typical dosages, side effects, and expected impact on recovery from both addiction and mental illness.

At the same time, since medically trained providers – nurses and physicians – absolutely need such knowledge, this book could serve them well in broadening their education. Even the most experienced or psychiatrically trained medical staff might find this book to be an excellent review and a handy reference text.

Whether medically trained or not, MMT staff must spend time educating patients, their family members, and others about the benefits of combining medication regimens with effective psychosocial strategies. This book can help provide necessary knowledge.

The author, Sophia M. Dziegielewski, PhD, LCSW, is Professor and Dean of the School for Social Work at the University of Cincinnati. She has researched and written more than 95 publications, and is the recipient of numerous honors and awards for her teaching. She is a source to which students and professionals alike have turned for up-to-date, accurate information on psychopharmacology.

Although Dziegielewski writes in a

Continued on page 7
straightforward manner, the subject is by its nature technical and there is a great deal of material covered. Some of the subjects include:

- An introduction to psychotropic drugs and the culture of today’s mental health treatments;
- How medications work: the basics of medication prescription and their use;
- The role of the non-medically trained mental health practitioner;
- Medications used to treat depression-related symptoms;
- Medications used to stabilize bipolar mood disorders;
- Medications used to treat symptoms of anxiety;
- Schizophrenia and the psychotic disorders;
- The role of herbal preparations, essential oils, and flower essences;
- Psychopharmacology in special populations.

The book has many reference tables providing at-a-glance summaries of key information. Throughout, there also are “Quick Tips” sections giving helpful suggestions for increasing medication compliance, coaching patients in using their medications properly, assessing signs of anxiety, and dozens of other topics.

Readers may want to first skim the book to get a broad impression of its contents, then read sections that are of immediate interest, and then retain the book for reference when medication issues arise in particular patients. One short-coming is that the book was not designed to specifically address potential interactions of the covered medications with methadone, and such interactions can be frequently problematic. Therefore, as a companion to this book, readers may want to consult the AT Forum paper on “Methadone-Drug Interactions” (available online at http://www.atforum.com/SiteRoot/pages/addiction_resources/Drug_Interactions.pdf).

Where to get this book...


Starting Methadone... continued from page 5

to take the drug only when they are in severe withdrawal and at least 10 hours after taking methadone. Patients should use only the smallest amount of drug necessary to relieve withdrawal symptoms, and to avoid alcohol, benzodiazepines, and street methadone. If possible, they should stay with supportive friends or family, and avoid contact with drug users or other drug-using triggers.

Guideline Validation

As a form of validation, Srivastava and Kahan distributed their recommended guidelines described above to all methadone-licensed physicians in the province of Ontario. Their consensus indicated that the proposed methadone-induction guidelines were reasonable and in keeping with the collective clinical experience of the several hundred physicians surveyed. Given the vulnerability and variability of patients seeking treatment for opioid addiction, it is important that MMT clinic staff exercise caution during the induction phase of methadone treatment. According to Srivastava and Kahan, evidence suggests that physician training and education, including the wide dissemination of guidelines such as these, can lower methadone-related overdose and death rates.


How Much Startup Methadone is Enough?

In proper balance, it should be noted that, through the years various approaches to methadone induction for MMT have been used; some more rapid than others, and some using higher doses than guidelines recommend. Current U.S. Federal regulations do allow for greater than 40 mg of methadone the first day if the program physician documents that more was required to suppress opioid withdrawal signs/symptoms.[2]

Furthermore, forensic research has shown that serum methadone levels (SMLs) associated with deaths and those considered therapeutic during MMT (or safe in opioid-tolerant individuals) overlap considerably. And, due to a variety of factors there usually is only a weak correlation between methadone dose and SMLs across patients.[2,3] Therefore, it is doubtful that any single methadone dose could be considered as inherently lethal in all opioid-addicted patients coming into MMT.[4]

Recently, in the November 18, 2006 edition of the British Medical Journal, clinicians Adam Bakker and Cindy Fazey reported matching the starting dose of methadone to patients’ predicted opioid tolerance levels and using starting doses of up to 150 mg of methadone. They acknowledge, “despite our use of starting doses that [government authorities] might well consider irresponsible, the only drug-related deaths in our series occurred after methadone had been discontinued.”[5]

These practitioners used an approach termed “methadone tolerance testing,” which involved careful questioning of patients regarding their prior opioid use and patterns of opioid withdrawal, and educating patients about the dangers of overdose risks if they misrepresented such opioid use. A starting, trial dose of methadone was matched to each patient’s estimated tolerance level and the patient was monitored very closely for signs of overdose.

Bakker and Fazey note that, “Our patients know they will be observed and that naloxone will be used if needed [to reverse methadone effects]. In practice, patients’ judgment of their dose requirement has proved accurate, and ... addicts who request high doses are likely to be those who [adapt] most readily and are thus least likely to succumb to accumulation.”

While this controversial approach could be risky and might not be recommended as routine, the authors assert that inadequately low methadone starting doses do not eliminate mortality. If the amount of methadone is less than their opioid requirement, patients will usually supplement it with illicit heroin, benzodiazepines, or other drugs until they have reached – or dangerously exceeded – their comfort level.
The AT Forum Spring 2006 edition (Vol.15, No. 2) featured an article on the "Perils of Pain in MMT." A followup reader survey asked about the mistreatment of pain among methadone maintenance treatment (MMT) patients.

The article noted that pain is a highly prevalent problem in MMT patients, with up to 4 out of 5 in some studies complaining of chronic pain. However, there were suspicions that these conditions often were being mistreated – either undertreated, untreated, or otherwise mismanaged.

**Mistreated Pain is Commonplace**

There were 186 responses to the survey, with the majority (61%) clinic staff members, 39% patients, and 4% “other.” Percentages of respondents who believed that MMT patients are indeed mistreated for their pain were overwhelming (see upper Graph); although, staff members seemed less inclined to acknowledge this.

Such mistreatment also occurs very often (see lower Graph). Again, MMT clinic staff were reluctant to portray the problem as nearly universal; however, only 1 in 10 of them believe that pain mistreatment rarely or never occurs.

**Many Sources of Mistreatment**

Where does the mistreatment of MMT patients’ pain occur? A majority of respondents (77%) indicated that private physicians most often provide inadequate treatment. Another 65% and 62% noted that pain mistreatment occurs in hospital emergency departments and during inpatient hospitalizations, respectively.

One third (33%) indicated pain clinics as providing deficient treatment, and 41% felt that MMT clinics do not provide adequate pain management. Percentages total to more than 100 because respondents could check all categories that applied.

As might be expected, these results suggest that healthcare providers with less training and experience in treating either pain or MMT patients tend to mismanage the pain. This implies that MMT patients must be somewhat selective in where they go for pain treatment and there is a need for better education of healthcare providers regarding pain management in this patient population.

**Stigma, Ignorance are Barriers**

In their comments, several respondents noted as a barrier the common misunderstanding among healthcare providers that methadone offers pain relief during MMT. And, patients who justifiably complain are assumed to be “drug seeking” and then denied adequate treatment.

An MMT staff member observed, “I had a patient who was denied her regular methadone maintenance dose in the hospital because they had already given her a small amount of morphine for pain.”

One patient wrote, “Most pain doctors won’t even evaluate you if you tell them you’re on MMT.”

An MMT clinic director said that they send a letter to patients’ primary care physicians informing them about principles of pain management for their patients. However, a patient commented that staff at her MMT clinic become suspicious when patients are prescribed opioid pain medications by outside physicians.

Clearly, there is a need for greater understanding as well much more effective communication among all healthcare providers who might be involved in the management of pain in MMT patients.