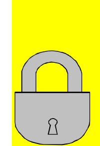
METHADONE MONTHLY

First Edition

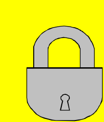
November 2005

We would like to welcome you to the first edition of our Methadone newsletter. The goal of our newsletter is to provide you with information about the Community, facts about Methadone maintenance and detox, and other articles of interest.

The Methadone Staff includes Donna our Nurse, who came to work here in October of 2001, three part-time Pharmacists, Angelo who started in 1980, Dennis who started in1996, and Dan who started in2002. We have two fulltime counselors, Jennifer worked here from Feb. 2001 to Sept. 2002 then returned in April of 2003, and Lupe who began working here in August of 2004.



Y ou HAVE to have a Lock box BEFORE you can receive your take home's
REMEMBER NO LOCK BOX – NO TAKE HOMES



This is a reminder that our office will be closed November 11th in honor of our Veterans.

We will also be closed on November 24th and 25th for the THANKSGIVING HOLIDAY!

FREE Prescription Discount Cards

Polk County has joined the National Association NACo Prescription Drug Discount Program, which means Polk County residents are eligible to save money on their prescription drugs.

Your discount card will be provided free of charge by Polk County. Everyone in the family may use the same card. This is not insurance; it is a prescription discount program. You will pay the lower of discounted price or the pharmacy's regular retail price. There are no claims to fill out and no limit to the number of times you can use the card. Your card cannot be used in conjunction with other insurance; However, you are able to use your card to purchase prescriptions that are not covered by these plans. To learn more about the program, like where you can get the cards & what pharmacies are participating, ask your counselor or the front desk.

Are problems sleeping common during MMT?

Many patients in methadone maintenance treatment (MMT) appear to have serious sleep disturbances.

The need for sleep varies from one person to another, but ranges up to 10 hours during a 24-hour period. Both the quantity and quality of sleep are important, and patients may complain that they do not sleep at all, when they are actually describing a lack of deep sleep, perhaps less spontaneous dreaming, and/or frequent awakenings.

Unfortunately, sleep can be disrupted by many factors, such as: psychological and medical disorders, effects of medications or substances of abuse, or lifestyle (e.g., lack of exercise). Persistent sleep disorders may be symptomatic of more serious conditions.

Persons who abuse alcohol and other drugs are at high risk for sleep disorders. This is due to the negative effects of those substances or their withdrawal on normal sleep patterns. Sleep is not immediately recovered even if drug or alcohol abstinence is achieved and, in fact, more normal sleep may require months or even years to return.

Specifically relating to opioid drugs, some studies have found that the primary effect on sleep of short-term *(acute)* opioid administration is to hasten falling asleep, but the restfulness of sleep and total sleep time are reduced. Long-term *(c chronic)* opioid abuse may lead to tolerance of some negative effects on sleep, although more serious insomnia may develop.

It is believed that methadone may contribute to insomnia by disrupting normal sleep phases during the night; however, the exact reasons for this are unknown. MMT patients also have a high prevalence of depression and anxiety disorders, which independently and negatively affect sleep. Small studies have indicated increased disruptions of sleep, including disturbed breathing (apnea), among methadone-maintained patients.

In one large study of MMT patients – receiving average methadone doses of 93 mg/day and an average of 3.2 years in treatment – most of the subjects (84%) had serious sleep problems. More than a third of them also had major depression and nearly half had general anxiety disorder. Depression, anxiety, nicotine dependence, body pain, and unemployment were significantly associated with poorer sleep quality during MMT; however, methadone dose was not a contributing factor in the overall analysis. Approximately 14% of the patients reported ongoing alcohol, heroin, and/or sedative abuse.

Untreated sleep disorders may influence continued drug abuse or relapse in MMT patients who are attempting to self-medicate their distress. Therefore, the use of non-addicting sleep therapies is critical in this population. In the final analysis, since opioids including methadone appear to affect sleep, MMT patients may have to accept some degree of sleep disturbance as a normal part of the addiction recovery process. However, it is vital to also consider that a return to more normal sleep patterns would require stabilized methadone maintenance and may take a great deal of time. For example, a person who is receiving inadequate methadone dosing could be frequently awakened during the night by opioid-withdrawal symptoms, including pain.

Unfortunately, there do not appear to be any published recommendations of pharmacotherapies for sleep specifically in MMT patients. The choice of which non-addicting medications might best help to resolve sleep problems and retain methadone patients in treatment needs further study.

For more information and references, see: Sleep Disorders in MMT. *Addiction Treatment Forum*. 2004 (Summer);13(3):1. Available at: http://www.atforum.com/SiteRoot/pages/current_pastissues/summer2004a.shtml#anchor2