

The **Methadone** Handbook



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Thirteenth edition

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The Methadone Handbook. Thirteenth edition.

I am very grateful to the many experts, drug workers and drug service users who have taken the time and trouble to help in the production of this and previous editions of the book.

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The Methadone Handbook is regularly updated and revised. If there are any comments or suggestions you would like to make, please send them to:

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Introduction

This handbook contains useful information for anyone interested in methadone treatment – whether you are already in treatment, starting treatment or just finding out more about it.

However, everyone is different and a booklet is no substitute for talking to an expert. If you can't find the information you need, want to know more about something or have any questions or worries, your drug worker, doctor or pharmacist should be able to help.



What are the benefits?

Methadone is one of the most researched medical treatments in the world. **The studies clearly show that adequate doses of prescribed methadone can help people who are dependent on heroin to:**

- **stop using heroin** (or greatly reduce the amount they take);
- **stop injecting** (or to inject less often and with less risk of HIV and hepatitis infection);
- **improve their physical health and nutrition;**
- **stop committing crime to get money to buy drugs;** and
- **have more stable relationships and to get on better with their families.**



Is methadone worse than heroin?

Whatever you have heard, methadone is not 'much more addictive' than heroin. There are two parts to drug dependence: the physical and the psychological.

Physically there really isn't a lot in it. If you actually stop (and stay off) heroin, the withdrawals will probably be more severe but shorter by several days than if you stop methadone. Psychologically (because it doesn't give a high like that of heroin) people tend not to crave methadone as much as they crave heroin.

Whichever way you look at it there isn't much in it. Methadone and heroin are both powerful drugs which can be hard to get off.

There are disadvantages to being in methadone treatment – such as having to pick up your methadone regularly, and not being able to go away at short notice. But being stable in treatment gives people the opportunity to build a life away from heroin use.

Prescribed methadone mixture also has the advantages of being:

- **regular;**
- **long-acting;**
- **inexpensive or free;**
- **legal;**
- **non-injectable;** and
- **accompanied by counselling, medical care and other forms of help.**

This means that, on balance, **for people who haven't been able to stop taking heroin** and who can switch their dependence to methadone, it is a much safer drug to be dependent on.

If you are thinking about starting methadone treatment, it might be useful to list the pros and cons of switching to methadone, and talk them through with a drug worker.



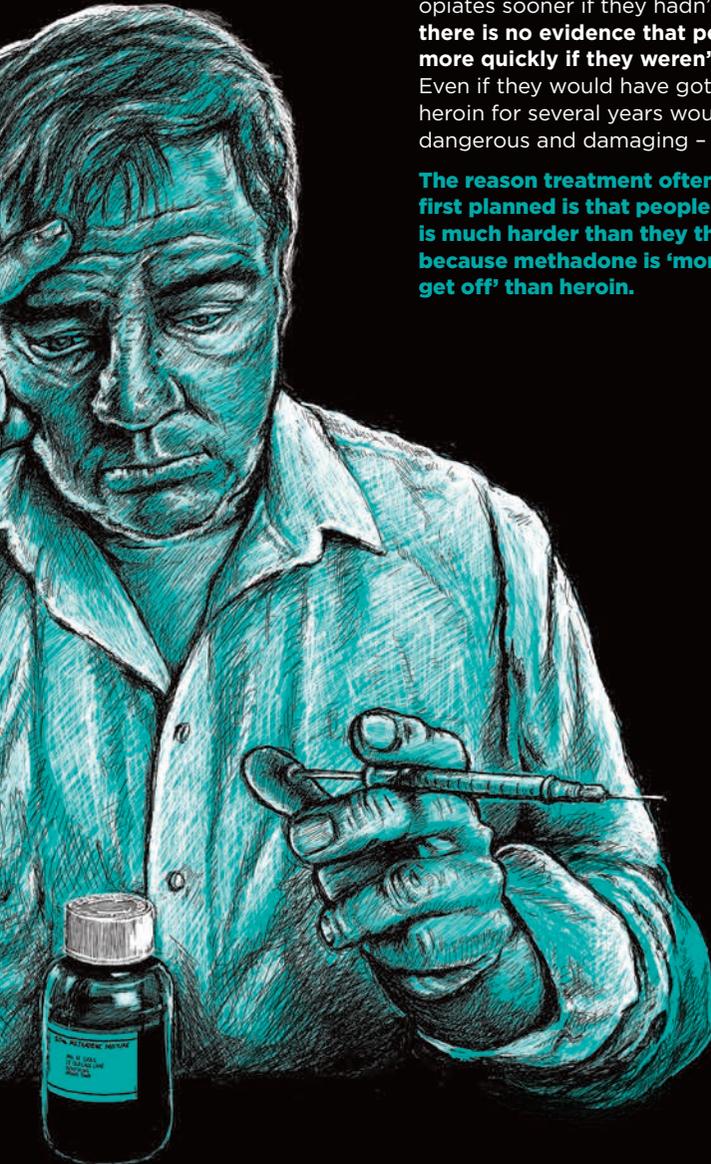
How long will it take?

For many people, becoming opiate-free is a long way off and, as long as methadone is helping avoid the risks of illicit drug use, it may need to be prescribed safely for many years.

It can be hard for people who have been on methadone for a long time: many wonder if they would have got off opiates sooner if they hadn't started treatment. **However, there is no evidence that people would get off opiates more quickly if they weren't prescribed methadone.**

Even if they would have got off sooner, taking illicit heroin for several years would have been much more dangerous and damaging – and possibly fatal.

The reason treatment often goes on longer than was first planned is that people find that getting off opiates is much harder than they thought it would be – not because methadone is 'more addictive' or 'harder to get off' than heroin.



The first few days

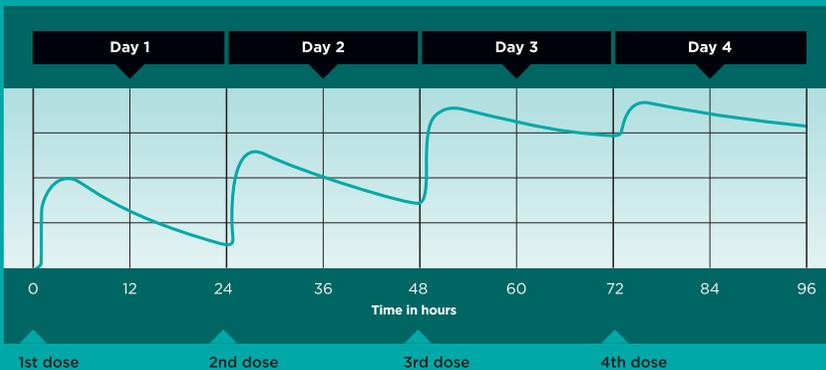
Methadone binds to cells in the liver, lungs and fat before moving back into the bloodstream to have an effect on you. This process is harmless and doesn't damage the cells at all.

This means that you won't get the full benefit of your dose during the first few days of treatment. It takes three or four days for these 'tissue reservoirs' to fill up and for the methadone to take full effect.

As you can see from the graph below, **you have much more methadone in your system four days into treatment than you do on day one or two.**

People often feel they haven't enough methadone to hold them in the early days of treatment. If this happens to you, keep taking the methadone as prescribed and talk to your drug worker or prescribing doctor. **The risks of overdose are very high if you use other drugs in the early days of treatment.**

The graph shows relative blood levels of methadone over the first four days of treatment.



Methadone usually takes around 30 minutes to start being absorbed, and around 4 hours to reach peak blood level.

Starting treatment

It is important to remember that you won't get a heroin-like hit from methadone. Although they are both opiates, the effects of methadone are less intense and come on more slowly. Some people find the change takes some getting used to, others don't find it a problem at all.

Taking more methadone will increase the risk of overdosing.

It is possible that you will be prescribed too much methadone. This can make you drowsy. If this happens – **especially if it happens with the first dose** – you should talk it over with your doctor or drug worker as there is a risk of overdose.

If, on the other hand, after a few days, your dose doesn't feel like it's enough, or if you are finding it difficult to stop using, talk to your prescriber or drug worker about it as your dose may need to increase. This is normally done over the first one to three weeks of treatment.

If you don't stop injecting once you are on methadone, make sure you have access to sterile needles and syringes and, to protect yourself from hepatitis B and C, use your own water, filters and spoons. You may want to talk to your drug worker or doctor about what effect it will have on your treatment if you continue to use on top.

Although methadone doesn't always feel like a powerful drug, it is, **and using heroin, alcohol or other sedatives (such as diazepam [Valium]) or sleeping pills (such as temazepam) on top of methadone is dangerous and can easily cause overdose.**

The ideal dose is one that:

- **is enough to get you adjusted to taking methadone instead of other opiates;**
- **stops you suffering from withdrawals;** and
- **doesn't over-sedate you.**

There are a few rare effects that can occur in the first few days of treatment, such as a swelling of the ankles and feet, painful and swollen joints and a skin rash. Although these usually go within a few days, you should discuss any side-effects with your prescribing doctor.



Methadone mixture

Methadone can be prepared as a liquid, tablet or in ampoules for injection. It is sometimes prescribed as Physeptone which is a trade name for the drug.

The Department of Health advises doctors treating opiate dependence to prescribe methadone mixture 1 mg / 1 ml. Different formulations are available and, although they may vary in taste and colour, the effect of the drug is always the same.

A few clinics dispense a concentrated methadone mixture that has 10 milligrams (mg) of methadone per millilitre (ml) of fluid. This means that people only need to take one-tenth as much liquid to get the same dose. **Taking 5 ml of concentrated methadone can be enough to cause overdose** in people who aren't tolerant. People used to 'ordinary strength' methadone can easily overdose if they take the same volume of the concentrate.

Although sometimes called 'linctus,' methadone 1 mg / 1 ml is 2.5 times stronger than linctus. Methadone linctus is mainly used to treat chronic, painful coughing and shouldn't be prescribed for opiate dependence.

Methadone is also available in 5 mg tablet form and in ampoules. The amps usually contain 10 mg of methadone per ml of fluid, although they can be much more concentrated with up to 50 mg per ml.

Tablets and amps

The Department of Health has issued strong advice to doctors not to prescribe the tablets or ampoules.

This is mainly because of the risk of illicit sales; and because of concerns about the risk of vein damage if the tablets or concentrated forms of the ampoules are injected. For these reasons you are unlikely to be prescribed methadone in any form other than the 1 mg / 1 ml solution.



Stability is the key

Methadone is more effective in helping people to stop using heroin when it is taken every day.

Having 'heroin days' and 'methadone days' results in very low blood methadone levels. As it can take three days for things to get back to normal, people who do this feel rough more often, and use more heroin, than those who take methadone every day.

Although there are highs that methadone can't give you, it can give you stability and control – but only if you are prescribed enough and only if you take it every day.



Effects

The main effect of methadone for many people is a dramatically reduced desire to take heroin. This effect is dose-related: although some people only need 30 mg a day to not want heroin, most will need to build up to 60 mg to 120 mg a day. This is the recommended dose range.

Everyone is different. **So when someone says ‘methadone makes you sick/tired/itchy’ etc., what they mean is that methadone has that effect on them – it may or may not have a similar effect on you.** You may experience only a few, some, or all of the effects listed below. You may experience them mildly or strongly.

There are some effects of methadone which are understood.

Its action on the brain can cause:

- **a high/mood change that is less intense but longer-lasting than heroin;**
- **controlling/levelling of emotions;**
- **drowsiness/sleep** – although this isn’t an issue for people who are stable;
- **nausea** – if you vomit after taking methadone it is more likely to be caused by a psychological or medical problem (or, if you drink, by alcohol) than by methadone – get your doctor to check it out;
- **slower, shallower breathing** (which is dangerous in overdose – see page 38);
- **reduced cough reflex;** and
- **reduction of any physical pain.**





Its action on nerves that control involuntary functions usually causes:

- **small pupils;**
- **constipation;**

and can cause:

- **dryness of the eyes, nose and mouth;**
- **reduced blood pressure;** and
- **difficulty in passing urine.**

In some people methadone causes the release of histamine (which is normally only released in allergic reactions) by rupturing the cells that produce and store it. This is not an allergic reaction.

Histamine release can cause:

- **sweating;**
- **itching;**
- **flushing of the skin;** and
- **narrowing of the air passages in the lungs.**

Methadone may also cause or contribute to:

- **reduced or absent menstrual periods** (see page 22);
- **reduced sexual desire** (see page 26);
- **reduced energy;**
- **a heavy feeling in your arms and legs;** and
- **a craving for sweet foods.**

The mechanisms that cause these effects are not always clear and some (such as no energy, reduced sexual desire and reduced periods) can be caused, or made worse by, other things in life.

The things methadone doesn't do...

Because it is a long-acting drug, methadone does not give the same 'hit' as heroin: most people can take it once a day without experiencing serious withdrawal symptoms.

In people tolerant to a stable dose, methadone won't affect:

- **co-ordination;**
- **speech;**
- **touch;**
- **vision;** and
- **hearing.**

And being on methadone doesn't make you more drug dependent.

Long-term effects

Methadone doesn't damage your:

- **bones;**
- **liver** (but see below if you have liver damage);
- **brain;**
- **heart;**
- **reproductive system;** or
- **immune system.**

Methadone does not damage any part of the body as it passes through.

The liver breaks down (metabolises) methadone into a form which can pass harmlessly through the kidneys into the urine.

However, in people who have a liver that is **very seriously damaged** (by illnesses such as hepatitis B or C or by alcohol), the extra work for the liver can cause overdose or liver failure. The danger is greatest at the start of treatment, when the dose increases, or if the condition of the liver deteriorates.





Methadone causes no direct physical damage, even if taken for many years, and is usually much healthier than being dependent on illicit opiates. People who are opiate-dependent (whether they are on methadone or not) can experience problems such as changes in sex drive, tooth decay and constipation. There is more about these on pages 26 and 27.

Tolerance

Tolerance is the way the body adapts in order to cope with the regular presence of some drugs. Once a tolerance has developed it takes bigger doses to achieve the same effect. **The tolerance you have built to other opiates is transferred to the methadone when you start taking it.**

If you detox, or don't take opiates for a few days, tolerance will quickly reduce. **After a break it is easy to overdose on an amount that, at one time, might not have seemed to have any effect at all.** This is why, if you miss a few doses, you may not get any more methadone until you have seen your prescriber.

One of the reasons why methadone is prescribed is that tolerance to it usually builds up very slowly.

The body builds up tolerance to most of the effects individually and at different rates. So your tolerance to one effect – such as feeling sedated – may have built up while you were taking heroin to the extent that you don't feel sedated at all when you start the methadone. But another effect – such as a dry mouth – may still be with you after a long time on a script.

People rarely develop a tolerance to:

- **constipation** (see page 27);
- **sweating;**
- **itching;** and
- **small pupils.**

If you need to be prescribed painkillers, your tolerance to opiates can cause problems. It may help to ask the doctor treating your pain to talk to the doctor treating your drug dependence – as you may need bigger doses of pain killers.

Chemist shops and pharmacists

This section may not apply to you as many prescribing agencies dispense their own methadone, and some have collecting from a local pharmacy as a second stage of the programme. So read, skip or save this section, depending on how you are going to pick up your methadone.

There are lots of grapevine tales about pharmacy staff with attitude problems – but remember, they have probably heard about (or had experience of) drug users with what they see as attitude problems too!

It is no good being at war with your pharmacist – there are problems that they can help you solve. It will pay off if you can find one of the many pharmacists who want to get to know and help you.

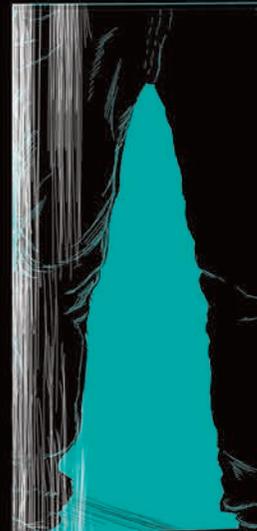
This information will hopefully help you to understand what the world looks like from their side of the counter and give you a realistic idea about what you can and can't expect from them – which will help you to avoid most of the arguments that people with scripts and pharmacists can get into.

Picking up take-home methadone

If your pharmacist seems to take ages to dispense your methadone or serves other people while you are waiting, it isn't necessarily because they hate you and think that you deserve to suffer.

It is probably because:

- **they make up prescriptions in the order they are given in.** Quite often people drop off a prescription and go and do their shopping; so just because the shop is empty it doesn't mean the pharmacist isn't busy;
- **methadone is a 'controlled drug' so there are strict regulations about how it should be measured out, recorded and dispensed.** One thing that does take time is the filling in of the 'controlled drugs register' which has to be done at the same time the prescription is handed out;





or because:

- **they are preparing a batch of methadone from the different ingredients** – which can take quite a while to do.

There are things you can do to make sure that you can pick up your methadone when you need it.

- **Get the agency writing your script to recommend a sympathetic, local pharmacist who stocks methadone (as not all do)** and, if possible, to introduce you personally. If they can't do this then someone should ring the pharmacy to tell them to expect you.
- **Pick up your own methadone.** If you do want someone else to pick it up, ask the pharmacist (who is entitled to say no) and introduce them to the person who will collect it. If that seems like a pain in the neck, imagine how you'd feel if you turned up for your methadone to find it had been stolen by someone who had said they were collecting it for you...
- **Write down the opening hours of your pharmacy.** If they've closed when you arrive there is nothing that can be done.
- **Agree with your pharmacist a time for collecting your methadone** that is convenient for you both; then they can try to have it ready for you to collect without a wait.
- **Carry some ID with you when you pick up your methadone** in case your usual pharmacist is off.

Supervised consumption

Supervised consumption can help improve how well people do in methadone treatment – **it stops people falling into the trap of taking methadone on some days and not on others (which lowers blood levels, and makes it less effective)** and it provides structure and routine, which is helpful for some. It also allows services to increase doses to the range which are likely to be most effective – between 60 mg to 120 mg – without fear of the methadone getting into the wrong hands and killing someone.

The Department of Health Clinical Guidelines say that, in general, everyone should be on supervised consumption at the start of treatment (to reduce the risk of accidental overdose), and that this should last for at least three months. **However, the guidelines allow for special arrangements to be considered for people who are working, or who live a long way from a suitable pharmacy.**

Each case should be looked at individually, as what might be suitable for one person will not necessarily be right for somebody else.





It can be frustrating, but if you are having problems don't just give up on treatment: talk about it with your keyworker or prescriber. It may help to write a note or letter giving details of the problems you are having.

Usually, people will move in stages from taking methadone under supervision to having take-home doses. Generally once people are stable there is a progression from supervised consumption to daily pick up (with two days on Saturday), then three times a week (say, Monday, Wednesday and Friday), then twice a week, and then weekly pick-ups.

Drug services would normally consider someone to be stable when they are:

- turning up for appointments;
- picking up all their doses of methadone;
- not taking illicit heroin (some services expect to see urine samples free of non-prescribed drugs before they will consider allowing take-home doses); and
- not drinking heavily.

If things aren't going well, the collection regime may go back a step or two in order to help get things back under control.

Women and methadone

A large proportion of women who use opiates experience reduced or absent periods.

This may be due to opiates reducing the levels of hormones that control menstruation, but can also be caused by stress, poor diet and/or weight loss.

It is important to remember that **even if you are not having periods you can still get pregnant.**

At any time during your treatment, but especially at the start or during detox (when desire to have sex may increase), you may get pregnant.

As well as protecting you from HIV, hepatitis B (see page 33) and other sexually transmitted diseases, **condoms can also stop you getting pregnant** – even when you aren't having periods.

Advice on condoms and other forms of contraception should be available locally from drug agencies, family planning clinics, sexual health services, HIV/AIDS services and GPs.



Pregnancy

If you think you might be pregnant, don't worry that the methadone may have harmed the baby. **There is no evidence to show that there is any additional risk to the development of the baby while you are on a stable dose of methadone.**

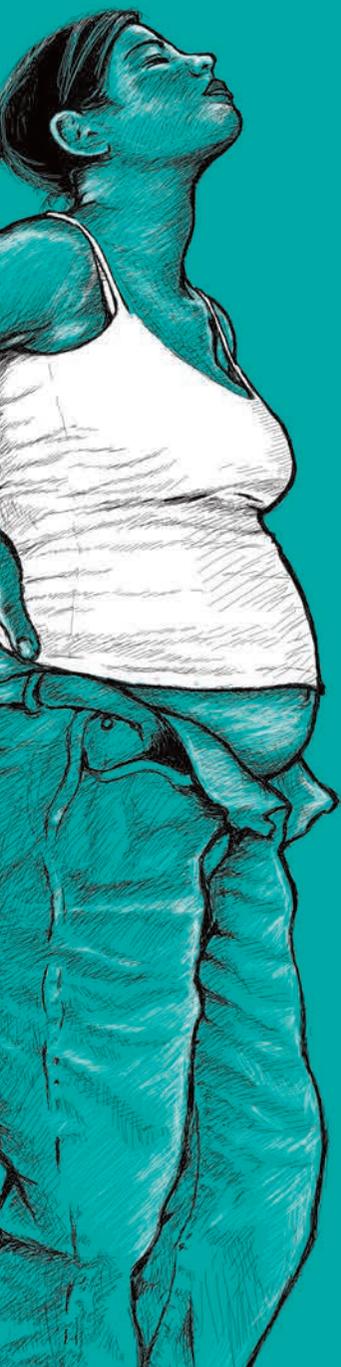
For the sake of their health and that of the baby, it is important that all women tell their GP they are pregnant as soon as they can.

A lot of women decide to come off opiates when they are pregnant. It is safe to detox during pregnancy - **but your doctor needs to help you plan and monitor any reduction.**

Stopping suddenly can be dangerous for you and the baby and should only be done under medical supervision.

Sometimes the stress and pressures of pregnancy make it hard to stop using and you could decide not to detox. If you are physically dependent on opiates, **being stable on methadone is better for the baby and you than being unstable on illicit drugs, especially if you are injecting.**

When you go into labour it is important to make sure the midwife and doctor caring for you know that you have been taking methadone and know about any other drugs you have used recently.



Babies

Many babies have been born to mothers using methadone, and large studies have shown that methadone does not damage the unborn child.

The baby can be detoxed in a few days – under medical supervision – without any long-lasting effects. If the baby is withdrawing, make sure the doctors know. Allow the baby to rest as peacefully as possible between regular feeds and avoid bright lights, which may irritate him/her.

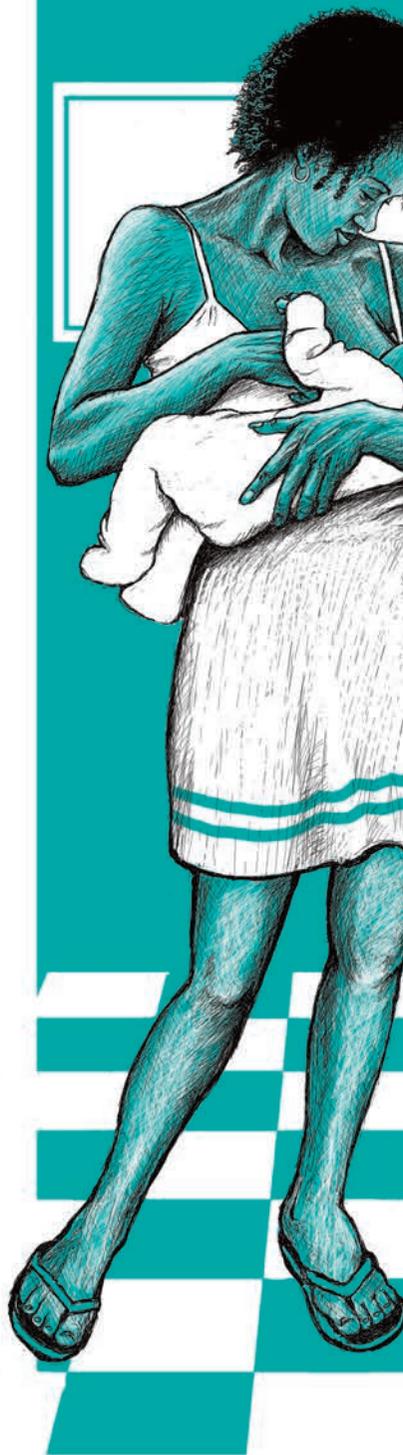
You must not give any drugs to detox the baby yourself, or ever give methadone to a child.

Children of opiate-using mothers are not automatically taken into foster care. If social services do have concerns, being in methadone treatment may help as it shows you are doing something positive about your drug use. By law, children can only be taken into care if they are at serious risk and after every effort has been made to keep them at home.

Breastfeeding

There are many benefits to breastfeeding and you can breastfeed while on methadone. Small amounts of methadone in breast milk can pass to the baby, but opinion varies as to how much the mother has to take before this happens. If this does happen it may reduce or prevent withdrawals in the baby after birth.

If you do breastfeed, it is important not to use drugs erratically. When you come to wean your baby, it is better to do it gradually to remove any possibility of withdrawals.



Children

If you can take your methadone home, make sure children can't get to it – they have no tolerance, so even very small amounts can kill them.

This is because methadone can make them:

- **stop breathing;**
- **vomit;** and
- **choke on their saliva or vomit because they can't swallow while unconscious.**

If you take methadone home and you have children, you should:

- **make sure your pharmacist gives you bottles with a child-resistant cap** (but remember even small children can open them!);
- **keep it in a locked cupboard** (sometimes wardrobes have locks already fitted); or
- **somewhere high, out of sight, that can't be reached by climbing;** and
- **talk to your children about the dangers of all medicines.**

Make sure methadone is never kept anywhere a child might find it.



Sex

Like all opiates, methadone can inhibit or remove the desire to have sex. In men it can affect the ability to get an erection. **These effects vary from person to person – and loss of sex drive can happen in relationships for other reasons.** This can be one of the most difficult side-effects of methadone treatment to live with. If it is a problem for you, it may be helpful to talk things through with your drug worker.

If you do have a sexual relationship, using condoms not only helps to prevent pregnancy, but can also protect you and your partner against HIV, hepatitis B and other sexually transmitted diseases.

HIV, hepatitis B (see page 33) and other sexually transmitted diseases live in body fluids: mainly blood, semen and vaginal fluid. **They are passed on when the infected body fluids of one person pass into the blood of another person.** The skin of the vagina, anus and penis is thin and easily damaged, so this can happen when people have penetrative sex without a condom.

Viruses get into the bloodstream even more easily when injecting equipment is shared. **Hepatitis C is a virus that can be caught easily through sharing injecting equipment** or paraphernalia such as water, filters, spoons, etc. but is rarely transmitted sexually.



Constipation

Constipation is one of the effects of opiates to which people rarely develop a tolerance, and chronic constipation can cause serious long-term problems.

Include lots of fruit and vegetables and alcohol-free drinks in your diet every day.

If constipation is a problem, talk it over with your doctor – especially if you are thinking about using laxatives. Some types of laxatives can be very helpful, but those which work on the muscles make things worse in the long term.

Teeth

Opiates are not good for your teeth because they can restrict the production of saliva which is one of the body's natural defences against plaque – the most common cause of tooth decay.

If you are prescribed methadone that is not sugar-free, it will be 50% syrup which can cause plaque. However, methadone is no worse for your teeth than eating sweets or taking sugar in tea and coffee! **And research has shown that the teeth of opiate users on methadone scripts are no worse than those of opiate users not on a script.**

To improve your dental health:

- **brush teeth morning and night with a high fluoride toothpaste** (use your own toothbrush as there is a risk of catching hepatitis C from using other peoples);
- **avoid snacking on foods and drink containing sugar, especially between meals;**
- **use a fluoride mouthwash daily, at a separate time to brushing;**
- **chew sugar-free gum for 20 minutes after meals to protect your teeth by producing saliva to neutralise acids;** and
- **visit a dentist at least once a year** (your drug agency should be able to put you in touch with one).



Going away

If you are thinking of going away, don't forget to sort out your script as soon as possible. The more notice you give, the less chance there is that you will have to cancel your plans because you can't get your methadone while you are away.

Your pharmacist can't dispense a day early because you are going away, nor can they give you methadone that should have been collected yesterday - legally they have to dispense according to the prescription.

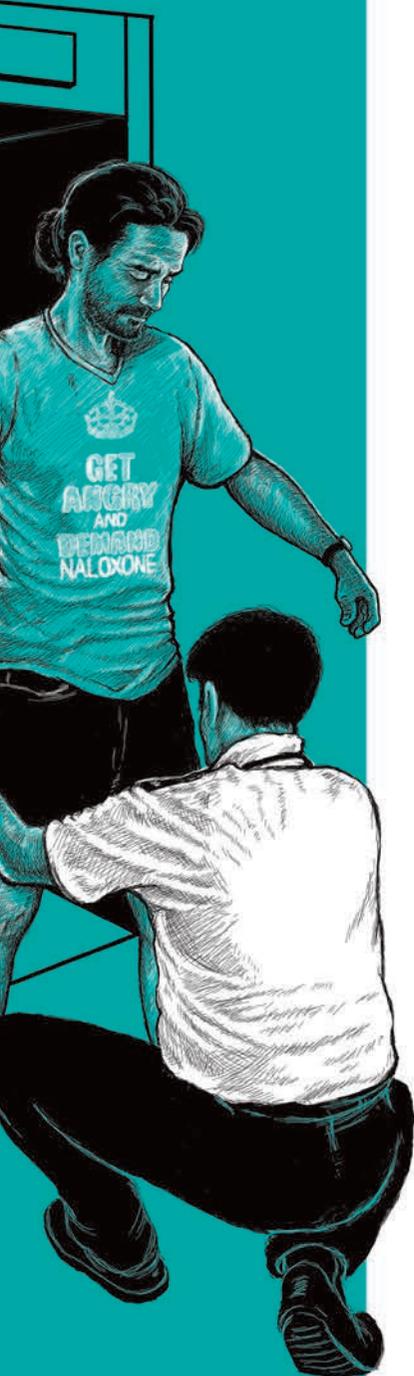
Going abroad

If you are travelling for over three months, or are carrying more than three months' supply of prescribed controlled drug medication, either abroad or to the United Kingdom, you should have a personal export/import licence from the Home Office. You will need to apply for this licence from the Home Office at least 10 working days in advance of your date of travel.

You will need to provide the following two documents in support of an application for a personal export/import licence:

1. a completed application form for a personal export/import licence which must be downloaded from the Home Office website at <http://tinyurl.com/36s7wp>
2. a letter from your prescribing doctor or drug worker containing the following information:
 - Your name
 - Your address
 - Your date of birth
 - The outward and return dates of your travel
 - The country you are visiting
 - List the drugs you are carrying, including dosages and total amounts.





If you are travelling for up to and including three months or carrying no more than three months supply, you will not need a personal export/import licence but you **MUST** still have a letter from your prescribing doctor or drug worker containing the same essential information as listed above.

For queries and guidance on licensing contact the Home Office at:

**Home Office
Drugs Licensing
4th Floor
Peel Building
2 Marsham Street
London
SW1P 4DF**

Tel: 020 7035 0467

Email: licensing_enquiry.aadu@homeoffice.gsi.gov.uk

www.drugs.homeoffice.gov.uk

Remember that when travelling, all controlled drugs should be carried in their original packaging as part of your luggage with your form and/or letter at all times.

Although following these guidelines will enable you to take methadone out of this country and bring any surplus back in, **it is important to remember that it doesn't mean you have the right to take it into the country/countries you are visiting.** You should check with the embassy or consulate before departure to ensure that the country/countries to be visited will allow you in with your methadone. This may take a long time.

The law

If you have any legal problems at all with methadone, or any other drug, the best people to speak to for advice, help and information are RELEASE – 0845 4500 215; or your solicitor, doctor or drug worker.

When it comes to deciding the penalty for certain offences, methadone is in the same class as heroin under the Misuse of Drugs Act 1971. As a Class A drug, charges of both unlawful possession and supplying methadone **(this includes giving or sharing as well as selling it)** are likely to be referred to Crown Court where the maximum penalty for unlawful possession is seven years plus an unlimited fine.

Selling, sharing or giving away your methadone can easily jeopardise your script, overdose a non-tolerant person and cause serious legal problems...

Custody

Police surgeons don't have to continue treatment prescribed by another doctor. Because there have been methadone overdoses in custody, some police surgeons are reluctant to prescribe methadone.

If the police confiscate your methadone on arrest, they should give it back on release.

Prison guidelines do allow for longer-term prescribing and it does happen in some progressive prisons. If you tell the prison medical service at the reception interview that you are on methadone, they may continue the treatment. You should at least get a seven-day detox, but, if you are pregnant, seriously ill or are on a maintenance prescription and are likely to be released soon, you should receive methadone as you would in the community.



Driving

The Road Traffic Act requires licence holders or applicants to tell the DVLA of 'any disability likely to affect safe driving.' They consider drug use to be a 'disability' in this context.

Once informed, they make you have a short, independent, medical examination which includes a urine screen for illicit drugs. **If there is only prescribed oral methadone in the urine, and you have been on a stable dose for a year, they will normally issue you with a licence for one year**, but if you are on injectable methadone they will withdraw your licence (because it is more sedating). You will be called back for another medical when your licence needs renewing (or when you reapply) and every year until three years after your script has stopped.

If the test is cannabis-positive, they withdraw the licence for six months. Regular users of cannabis will test positive for up to a month from last use. If other illicit drugs are found, they remove the licence for one year. There is another medical on reapplication for the licence, and every year for three years, once it has been returned.

It is an offence to be in charge of a vehicle when 'unfit to drive through drink or drugs' - this includes prescribed ones. **If you do carry on driving on a script, take care and don't drive if you feel sedated or if you have had any alcohol.**

If you are involved in an accident and your insurance company finds out that you are on methadone, they might be able to claim that it invalidates your insurance.



Hepatitis C

Hepatitis is a medical term that means ‘inflamed liver.’ All the hepatitis viruses can cause damage and swelling of the liver. They live in blood and other cells and can damage the liver.

The two main types transmitted by sharing injecting equipment and paraphernalia are hepatitis B and C.

About one in three injecting drug users have hepatitis C. This is because even tiny amounts of blood can cause infection. Both can be carried (and passed on) for years without people being aware that they even have the virus.

The symptoms of liver disease caused by hepatitis include:

- **tiredness and depression;** and
- **tenderness and abdominal pain.**

If you have hepatitis, alcohol and paracetamol can accelerate liver damage. If you have hepatitis C and you drink alcohol regularly you are much more likely to get serious liver disease. See page 35 for more information on alcohol.

If you are hepatitis C-positive and are going to be prescribed methadone, you should make sure the prescribing doctor knows about your diagnosis.

Your doctor should be able to tell you about the monitoring and treatment options that are available to you.

There is more information on how serious liver damage can affect methadone treatment on page 16.



HIV

Studies have shown that, for people with HIV, methadone is much better than illicit opiate use. This is especially true for injectors because injecting can accelerate the progression of HIV-related illness by affecting general health and introducing bacteria directly into the bloodstream.

If you are on methadone, the doctors managing your HIV need to know because methadone interacts with some anti-viral treatments.

If you are HIV-positive, you can discuss your treatment with your:

- **GP and/or prescribing doctor;**
- **drug worker;**
- **local HIV/AIDS service;** and
- **pharmacist.**

Or you can ring the **Sexual Health Helpline on 0800 567 123** – they will be able to give you advice and information and details of local services.

Hepatitis B

There is a vaccination that can stop you catching hepatitis B. It is a course of three or four injections. **Your GP or drug service should arrange vaccination for you: if they haven't done it yet – ask.** Even if you are immune to the hepatitis B virus, you still have to protect yourself from hepatitis C and HIV.

If you have hepatitis C it is even more important that you are protected against hepatitis B, because being ill with hep B can cause serious liver damage.



Methadone and other drugs

Although methadone doesn't react with or affect most prescribed drugs, always check with a pharmacist if you get a prescription for something else or are buying over-the-counter medicines.

If you go to the dentist or a doctor other than your prescribing doctor for treatment, tell them you are prescribed methadone.

This is especially important if you need treatment for:

- **pain;**
- **epilepsy;**
- **TB;**
- **depression;**
- **HIV;** and
- **anxiety or poor sleep.**

If you take buprenorphine (temgesic/Subutex) while on methadone, you may go straight into withdrawals because it is a different type of opiate, and will expel methadone from the opiate receptors.

You will also go straight into withdrawals if you take the drug naltrexone – which is sometimes prescribed to help people stay off opiates.

Methadone blocks the receptors in your brain that heroin and other opiates have to fit into in order to have an effect. So, if you have any methadone in your system, heroin may have a reduced effect or none at all. **If you try to take enough to get a strong effect, you run the risk of overdosing.**

Taking any sedatives in conjunction with methadone can be dangerous as they make each other more effective and increase the risk of overdose (see page 38). Particularly risky are the tranquillisers like diazepam (Valium) and temazepam which, as well as being an overdose risk, stop people thinking clearly and so increase the chances of sharing used injecting equipment or paraphernalia.



Alcohol

Methadone and alcohol boost each other's effect.

So if you overdo either or both, you are much more likely to overdose. And as they can both knock you out and make you throw up, you don't have to take a lethal dose to end up choking to death on your vomit whilst being too sedated to wake up.

If you find that methadone doesn't seem to be enough for you, talk to your doctor or drug worker about it rather than drinking more alcohol.

The effects of alcohol are not altogether different from methadone and sometimes when people feel like they need more drugs they use alcohol.

The trouble is that drinking levels can creep up, and can do you more harm than opiates – especially if you have hepatitis C.

If you drink alcohol regularly it is important to discuss your levels of drinking with your doctor or drug worker. Recording how many units you drink and setting yourself limits may help you keep things under control and stop it becoming a problem.



Withdrawals

When you have developed a tolerance to methadone (see page 17), you may react – or withdraw – when the amount of methadone in your system drops.

Every part of you that is affected by the methadone learns to cope with the drug inside you, so if you stop taking methadone your body takes time to adjust to not having it there. **During that time you may suffer withdrawal symptoms such as:**

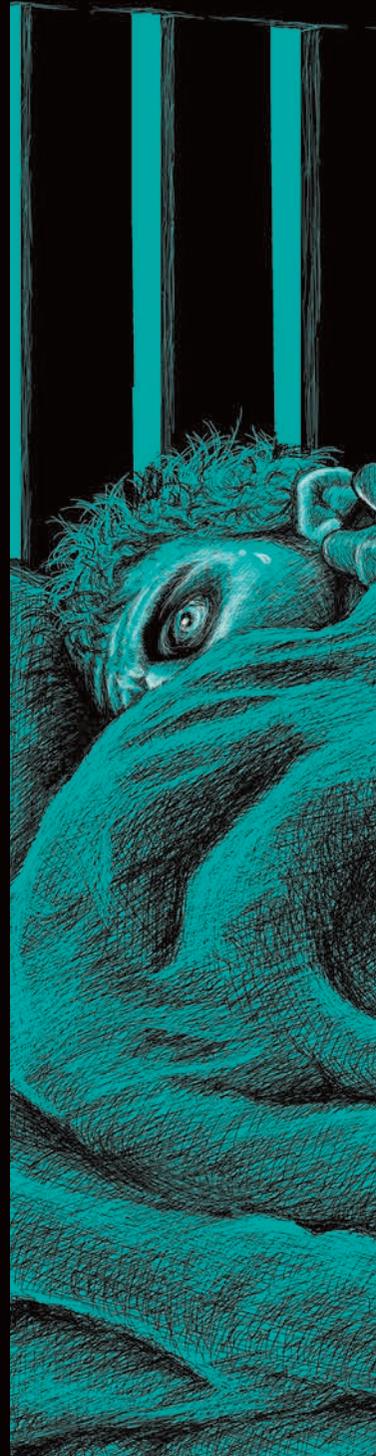
- a high temperature but feeling cold;
- goosebumps alternating with sweating;
- restlessness;
- feelings of anger and/or anxiety;
- jerking arms and legs;
- disturbed sleep;
- feeling or being sick and diarrhoea;
- running eyes and nose;
- pains in muscles, bones and joints; and
- yawning and sneezing.

Most physical withdrawal symptoms are probably caused by the body continuing to overproduce a chemical called noradrenaline. Noradrenaline is responsible for controlling many automatic body functions – such as digestion (see page 15).

Opiates may also reduce the secretion of the body's natural opiates called endorphins. This may partly explain why people feel anxious, cold and/or have difficulty sleeping for a long time after coming off opiates.

Because methadone is a longer-acting drug, most people find the withdrawals longer-lasting than with heroin, but there isn't much in it. The mechanisms of readjustment are essentially the same whether you've stopped methadone or any other opiate.

The ability of your body to readjust to being opiate-free is not something that you have complete control over. For some it just doesn't happen, and for them being on long-term methadone is the only way they can lead a 'normal life.'





Detoxing

Coming off and staying off opiates can be very difficult: there is another handbook in this series – *The Detox Handbook* – which looks in detail at the whole issue of getting off opiates.

How and why you want to detox and what you expect at the end are things well worth talking over, at length, with your drug worker and/or doctor.

Slow detoxes don't usually work any better than fast ones. It is almost always best to stay on a stable dose and come off over two to three weeks when you are ready.

If you choose to detox and then use heroin while coming off, your chances of staying drug-free afterwards are slim. If you want to get off heroin, stop using at the start of the script or detox – if that isn't the right time, it will be hard to find a better one. If you can't, you might be better off getting stable on methadone before starting to detox.

Each time you take a drop in dose on a long detox or throughout a quick one, there are several **things you can do to help make the adjustment easier:**

- **if you can, plan to take it easy for a few days after each drop;**
- **keep things as stress-free as you can;**
- **look after yourself** – stay warm, eat well and drink plenty of alcohol-free fluids; and
- **don't keep an emergency supply because if you do you'll only find emergencies!**

Detoxing isn't just about withdrawals. There will be changes: opiates tend to flatten out highs and lows in life so **you will probably find that feelings are more intense than you've been used to.** Most people find that as time goes by their emotions become easier to control.

Detoxing isn't the end: staying off is harder than getting off. If it doesn't work out don't give up – get back into treatment and either try a stable dose or another detox.

Overdose

Being in methadone treatment reduces overdose risk.

Some of the things that increase the risk of overdose are:

- **not being in methadone treatment**
- **mixing methadone with alcohol/tranquillisers; and**
- **injecting heroin after a detox or break.**

If you detox, or stop using opiates for a while, **your tolerance will reduce. So, if you do use on top of a low dose, or go back to heroin after a break, you could easily overdose on the amount you used to take.**

Remember

People who are not tolerant to methadone can easily overdose:

- **as little as 10 mg can kill a small child;**
- **a mouthful can kill a teenager;**
- **less than 50 mg can kill a non-tolerant adult** (and that could include you! – see above);
- **using tranquillisers and/or alcohol at the same time as opiates makes overdose much more likely; and**
- **most of the people who die from methadone overdose have been sold it by someone who has got a script.**



If someone overdoses don't assume they'll come round

**If someone is unconscious and breathing
put them in the recovery position**

To do this:

Open their airway by tilting the head back and lifting the chin.

Straighten the legs.



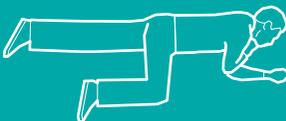
Place the arm nearest to you at right angles to their body.

Pull the arm furthest from you across their chest and place the back of their hand against the cheek nearest to you.

Get hold of the far leg, just above the knee, and pull it up, keeping the foot flat on the ground.



Keep their hand pressed against the cheek and pull on the upper leg to roll them towards you, and onto their side.



Tilt the head back to ensure they can breathe easily.

Make sure that both the hip and the knee of the upper leg are bent at right angles.

**Dial 999 and ask for an ambulance
Stay with them until the ambulance arrives**

Essential information for anyone interested in methadone.

**‘Easy to read and yet full of facts.
The Alliance recommends it to all...’**

Bill Nelles, The Alliance

Handbooks available in this series:

Methadone

Code: P301

Detox

Code: P302

Safer Injecting

Code: P303

Rehab

Code: P304

Also available – Treatment Choices:



Methadone
Code: P801



Buprenorphine
Code: P802



Naltrexone
Code: P804



Suboxone
Code: P805
