

Methadone Today

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Why the Clinic System Must Go - by R.B.

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(<http://www.atwatchdog.org>).

I have often thought--over the 25+ years I've spent on methadone maintenance treatment (MMT)--that perhaps the superlative proof of just how wonderfully effective MMT is, lies in the fact that so many patients do so well with it, despite the fact that the clinic system (methadone maintenance treatment programs--MMTPs) is "designed for failure"--i.e., the very founding assumptions of MMT clinics, to say nothing of how they actually operate, undermine patients' well being and dignity in countless ways.

MMTPs were integrated under the various states' pre-existing "drug abuse" treatment agencies. Almost without exception, these agencies (still!) operate under the "mental health" model of drug dependency, married to the AA/NA 12-step "philosophy." The result of this shotgun wedding of two modalities which are of dubious validity for opiate dependency to begin with, was the creation of an approach to MMT that combined the worst aspects of psycho-babble social-workerese, parole agencies, and the revival tent ambience of a 12-step meeting.

Methadone, as a drug for opiate maintenance, was isolated from all other drugs in the pharmacopeia and thus demonized as if it were some sort of supremely dangerous substance, requiring the kind of endlessly detailed protocols which bring to mind radioactive isotopes. Layered atop the federal and individual states' rigid rules and regulations for clinic operation have been the completely arbitrary set of policies of the clinics themselves, which were and are subject to the particular agendas of program directors--who have what amounts to the power possessed by tin-horn dictators over patients' lives.

Clinics were--and many still are--staffed by clueless "counselors"--"90-day wonders"--whose first introduction to the concept of MMT often occurs at their employment interviews, and by "medical directors" who all too often are incompetents, or merely the kind of scape-the-bottom-of-the-barrel physicians typical of those who work at prisons or who restrict their practices to giving insurance company and employment physicals. (Cont. p. 3)

Methadone Treatment and Prison --the Benefits

*Work Cited: Sara L. Johnson, Jennifer T. C. van de Ven, and Brian A. Grant. *Institutional Methadone Maintenance Treatment: Impact on Release Outcome and Institutional Behaviour*. Addictions Research Centre, Research Branch, Correctional Service Canada.

Way back in the June 1999 issue of *Methadone Today*, we reported that Canada was going to provide methadone maintenance to inmates. Enough time has passed to enable long term studies of methadone maintenance treatment of inmates and its consequences.

Until these kinds of studies* were conducted, we only had general studies regarding methadone maintenance treatment. In other words, the studies looked at methadone patients in general--not among current or former prison inmates. In fact, none of the patient subjects in the studies initiated or received methadone treatment while in prison (if they had ever been in prison).

These studies gave some idea of the potential for MMT in prison--opiate addicts' amount of illicit drug use and criminal activity went drastically down while in treatment. From these studies, it seemed nearly certain that providing methadone treatment in prison would reduce recidivism, but to what extent? For example, if opiate addicts in prison have been addicted and/or been involved in serious criminal activity longer than opiate addicts seeking methadone treatment in general, would methadone maintenance have less of an impact on the amount of criminal activity they engage in [once they are released from prison] than for methadone patients in general?

The results of these studies are important if we want to convince policymakers and the public that providing methadone maintenance treatment to prisoners is a good idea. For one thing, studies that demonstrate the benefit providing such treatment would have to the public, may be able to neutralize that argument used by prison officials that methadone treatment in prison will only lead to problems--specifically, that methadone will be diverted to other inmates and abused.

It is interesting to note that in Canada, the main impetus for the provision of methadone maintenance treatment in prison was the incidence of needle sharing and with it, disease transmission (HIV and Hepatitis C). Methadone maintenance treatment was viewed as a more politically acceptable solution than providing (Cont. p. 3)

MMT Patient Faces Manslaughter Charges

Those who sell (or give away) a controlled substance, including methadone, risk manslaughter charges should the recipient fatally overdose on the drugs. Of course, sale of the drug itself is usually a felony which may result in substantial prison time, depending upon the particular drug and the quantity being sold and possessed, etc., but a manslaughter charge may carry a far stiffer prison sentence than drug dealing charges.

In Portland, Maine, a methadone patient has been indicted for manslaughter. He did not even sell it; he **gave** his take-home dose to a man who subsequently died of a methadone overdose.

Along the same lines, some states, including Maine, are contemplating amending their laws to make it easier to convict drug dealers of manslaughter in cases where the buyer fatally overdoses on the illicit drugs. In fact, such a law already exists at the federal level where "career criminals" face mandatory life in prison where someone fatally overdoses on the drugs supplied by the dealer.

Methadone patients contemplating the sale of their take-home doses should think carefully about the potential legal consequences of what they are planning to do. The sale of a single take-home dose could mean a lengthy prison sentence--or even life in prison (in many cases, one take-home dose would be enough to kill an adult). It is doubtful that most methadone patients who sell their take-home doses realize the consequences they may face for selling a small amount of a controlled substance.

To anyone considering selling their take-home doses: making a few dollars is not worth your freedom! Besides, the people that sell their medication are causing problems for the vast majority of the law abiding methadone patients who do not do so. When the public sees drug dealing near a methadone clinic or reads about someone dying of a methadone overdose, it maintains their negative view of methadone treatment and patients. This is one of the reasons residents often battle the opening of a clinic in their neighborhood, state politicians oppose efforts to expand the amount of take-homes allowed and the availability of treatment in general.

Testosterone and Methadone Treatment (from p. 4).

frustrated--he knew it was from methadone, but since he had not told his urologist he was taking methadone, he had to wait.

The doctor then spoke with Chad's wife. She told the doctor that Chad had been taking Vicodan for the past three years (trying to account for opiates causing the low T) and went on to explain that chronic administration of opioid-based medication may cause low testosterone. The doctor then said that he would have to do some research on this, but he thought that Chad would have to go see an endocrinologist because his pituitary hormone levels should not be low. His wife commented that opiates could cause this also.

Chad was upset that he had to go to another doctor after all this time. The urologist called back a few days later and said that he had spoken to the endocrinologist and was sending Chad for an MRI of his pituitary gland--if the MRI came back normal, he would start him on testosterone replacement therapy. Chad went for his MRI which came back fine, and he was started on testosterone therapy.

When getting testosterone replacement therapy, there are different administration options, such as the newest form, which is a gel marketed under the brand name ANDROGEL. There are also two different types of patches, Testroderm and Androderm. One is a patch that goes on the scrotum; the other is a patch that is placed on the arms, legs, back, or stomach area. Chad began with ANDRODERM, the arm/leg patch.

There are also pill forms of TRT (Testosterone Replacement Therapy), but these are the most damaging to the liver and are not recommended. And lastly, there is an injectable form, given every 12-17 days. It is a thick liquid, and I have been told it hurts quite a bit. Also a plus to the ANDRODERM patches is that the T is time released, and it does not give the patient the highs and lows of TRT injections.

Low libido (sex drive) is NOT just a symptom of methadone maintenance that you have to live with. Do something about it; see your primary care doctor or go right to a urologist if your insurance allows it. I suggest you tell the doctor that you ARE taking methadone or you very well may have to go through a month and a half of tests like Chad did. There IS treatment, and you are entitled to it!

Also, please tell all of your friends on MMT about this. Most clinics do not tell their patients about this side effect [CAP, Dr. Marc Shinderman's clinic is a notable exception].

Editor's Note: Beth Miller is a valuable patient advocate (she is not a doctor) who has done some research that may be helpful to some patients. That methadone **causes** low testosterone levels is only a theory. Decreased libido is one of the most common side effects of methadone treatment, but the precise cause is not clearly understood. It appears that most male methadone patients experiencing low libido do not have other symptoms associated with low testosterone levels (body hair loss, ingrown hair and irritability), so it is highly questionable whether methadone treatment **causes** low testosterone levels. In 1999, Dr. Marc Shinderman and a colleague conducted research into sexual dysfunction and methadone treatment (see next column) but did not use TRT, and he suggested increased prolactin levels, not low testosterone, may be the cause of the sexual side effects.

Even so, we believe that the suggestions made in the above article are helpful. That is, male methadone patients experiencing sexual dysfunction would be wise to have their testosterone levels tested; then, depending on the results, the physician can choose to treat the problem with TRT, a treatment like that discussed by Dr. Shinderman or some other treatment. Note that unlike TRT, the treatment described by Dr. Shinderman is also useful for female methadone patients.

Sexual Dysfunction Treatment with Bromocryptine

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**The following is a summary of a presentation made at the 1999 ASAM (American Society of Addiction Medicine) Conference*

Diminished sexual interest and function due to methadone maintenance treatment (MMT) is a common complaint among our MMT patients, which sometimes adversely affects treatment outcome. Lowering of methadone or LAAM dosage and/or stimulant (cocaine) abuse are examples of strategies reported by our patients in attempts to restore lost libido. We were aware that MMT patients demonstrate elevated prolactin levels. Non-opioid dependent individuals who develop hyperprolactinemia from prolactinoma (benign pituitary tumor) or taking antipsychotic medications demonstrate an array of sexual dysfunction signs and symptoms, as well as weight changes. In men, decreased libido and impotence are the main presenting complaints. Hyperprolactinemic women commonly experience cessation of menstruation, galactorrhea and infertility, as well as diminished libido and inorgasmia. The treatment of these symptoms, for decades, was Bromocryptine (BRC), which decreases prolactin by enhancing dopaminergic tone. Decreased prolactin levels in BRC treated patients are correlated with normalization of decreased testosterone and other hormonal abnormalities, resumption of menses, as well as restoration of libido and erectile function. A colleague, A. Tagliamonte, M.D., of Cagliari, Italy, advised us of 17 male MMT patients of his, who complained of loss of libido, had high prolactin levels and whose symptoms responded to Bromocryptine therapy.

We hypothesized that the increased prolactin levels in MMT patients reduced libido through anterior pituitary-gonadal interaction, as in these other conditions. We prescribed BRC to 19 patients (13 male and 6 female) in methadone maintenance treatment who had reported some sexual dysfunction. These problems included loss of sexual interest, absent or delayed orgasm, and (for males) erectile dysfunction.

Overall, the results indicate that approximately half of the patients who had reported some impairment in sexual function experienced a significant improvement following treatment with BRC. Among the female patients, half (3 out of 6) reported a significant increase in sexual interest. Among the 13 males who had reported a complaint, 70 percent reported a moderate or better increase in sexual interest, 57 percent reported a moderate or better improvement in orgasmic dysfunction, and 50 percent reported a moderate or better improvement in erectile function. No apparent differences between responders and non-responders were evident in regard to age, time in treatment or methadone dose.

Our study does not demonstrate that increased prolactin levels in MMT patients cause diminished sexual desire and function. Obtaining prolactin levels prior to treatment and monitoring changes would have helped to clarify this issue. The purpose of our intervention was to find a treatment that alleviated our patients' complaints. Our results suggest that any strategy that increases dopaminergic tone might be useful in treating sexual dysfunction in this population. Medications with lower side effect profiles, such as cabergoline, a newer dopamine agonist requiring only twice weekly administration, or bupropion, might be better choices than Bromocryptine for most patients.

We believed that the dramatic weight gain seen in some MMT patients might be linked to prolactin levels but were unable to demonstrate this because most of the patients took medication sporadically. Patients who become obese in treatment frequently associate it with methadone, as do those with sexual dysfunction. Of the few patients who took BRC daily for a period of more than 90 days, one female showed a 20-pound weight loss. In MMT patients with complaints of obesity or sexual dysfunction, hyperprolactinemia should probably be considered among the causes.

The Clinic System Must Go (from p. 1).

No one else in American society--not paroled killers, not even child molesters--is subjected to what amounts to parole without end with, at best and only after years, a weekly reporting schedule and submission to degrading "monitored urines" on demand--for life. Until recently, this was the rule at most MMTPs.

Although the recent changes in federal regulations are a breath of common sense, decency and fairness, they are linked to and depend upon withholding accreditation for "persuading" the clinics to come into compliance: there is no direct legal compulsion for them to do so, and many are resisting every inch of the way--because they see these changes as a threat to their lucrative monopoly over MMT.

The new regulations make possible, for the first time in about a century, the reintegration of the treatment of opiate dependency into regular medical care. Although at present, this is available only to patients with a relatively long treatment history and exemplary records. The clinics see the handwriting on the wall--and they do not like it!

For over thirty-five years, the clinics have surrounded methadone and MMT with mystification. They have gotten away with this largely because their creation spawned an entire class feeding off of methadone patients--so-called "counselors," administrators, nursing staff, "medical directors," etc. They have learned the one lesson rudimentary for all bureaucrats--how to create an endless series of "look busy and important" non-essential (or totally useless) tasks, and how to take several paragraphs to convey information which could have been contained in one sentence. The MMTP "scam" relies upon putting the idea over on the funding public that the clinics are providing some sort of highly individualized, highly intensive "treatment" by "addiction experts," and that "counseling" (presumably of a "psychological" nature) is something absolutely critical for "recovery."

The truth of the matter should outrage us all: what the clinics are providing is a relatively cheap medicine its "clients" need in order to function--and surrounding the administration of that medicine with an enormous collection of hocus-pocus pseudo-expertise and rigamarole, which not only wastes millions of taxpayer dollars, but (in many clinics) bleeds paying "clients" like a loan shark, while treating them like untouchables.

In New York State, for example, Medicaid "reimburses" the clinics at a rate of about \$100 per week for each "client." Just what justifies this compensation for doling out a medicine that costs a small fraction of that, at weekly or even twice-a-month clinic visits, with a mandatory "counseling" session each month, which most patients neither want nor need? Taxpayers have begun to wake up to the

inordinate fees charged to the public purse--for providing a service which could be performed better and more cheaply at a physician's office--and that awareness naturally has resulted in the public balking at funding MMTPs.

Yet, as bad as the bilking of the public is, the fees charged to working patients are disgraceful in many, many clinics. Patients pay \$150 a week and more at many clinics--and for someone making a near minimum wage salary, there is no way on earth that food, clothing and shelter expenses can be met while paying the clinic what it demands.

The reintegration of opiate maintenance treatment into mainstream medical practices can and must be done--but it must be done right. Beginning with a group of well-established MMT patients, with proven track records for stability, makes sense. The critical question is the case management of those new to MMT or of patients with less stability. I suggest making use of the experience of those of us who have done well under MMT over many years; many of us are now in our 40s, 50s and older and would welcome the chance to contribute to establishing private practice or mainstream medical clinical practice OBOT protocols for case management. We could work as mentors and as liaison between patients and

We know that OBOT practices--and their patients--will be held to a standard demanded of no others.

practice. We know MMT--what works, what doesn't. As patients, it is most emphatically in our interest to see that OBOT works: we know that OBOT practices--and their patients--will be held to a standard demanded of no others. If a patient prescribed sleeping pills or tranquilizers overdoses or sells his/her medicine, the newspapers, the public and government agencies do not demand that all patients receiving sleeping pills or tranquilizers begin attending a clinic daily and take their medicine in front of "staff"--but any untoward publicity due to the actions of a few "rotten apples" could easily result in exactly that for all MMT patients again. That would not be in the interests of the great majority of MMT patients, of their OBOT physicians, of the tax-paying public (which includes most MMT patients!), nor of anyone but the clinic system "providers."

Editor's Note: The views expressed within the newsletter are the opinions of the authors. *Methadone Today* does not necessarily share these views. While the author's negative characterization of methadone clinics and staff

is an accurate assessment of the situation at too many clinics, we are reluctant to use broad generalizations that malign all the good treatment providers and staff who do the best they can while often contending with backward state regulations and policymakers. But we agree that the clinic system forces indignities on many methadone patients.

MMT and Prison (from p. 1).

clean needles to inmates. Perhaps studies outlining the benefits to the public of providing methadone maintenance to inmates [beyond health care costs], will result in greater public support for it. Ultimately, the public may permit and even call for making methadone maintenance treatment available in every prison--not only for those who were in methadone treatment prior to being incarcerated, but for all opiate addicted inmates.

Research Findings*:

As expected, in comparison to the opiate addicts not provided MMT in prison, after release on parole, a smaller percentage of MMT inmates committed new crime[s]. Furthermore, a smaller percentage of MMT inmates had their parole revoked and/or were convicted of a new crime and re-sentenced to prison. Parole may be revoked for a technical violation of the terms of parole, so the majority of inmates who have their parole revoked did not actually commit a new crime. Fewer MMT inmates had their parole revoked for either a technical violation or for committing a new offense. Specifically, at a 12-month followup, 62% of the MMT group had not returned to prison due to a parole violation or re-sentence, whereas only 39% of the non-MMT group had not returned to prison.

Considering the expense of incarceration, these results indicate a serious economic benefit to the public would be reaped by offering MMT to all opiate addicts entering or already in prison. Besides, if society is serious about rehabilitating offenders, this is one effective means for those inmates who are addicted to opiates. Offenders who are provided MMT in prison are far more likely to continue treatment after release. MMT allows patients to function, obtain legitimate employment and cease criminal activities.

Finally, prison officials that oppose making MMT accessible should consider that once opiate-addicted inmates began MMT, serious drug charges went down. This was in marked contrast to the non-MMT group that actually had an increase in serious drug charges while in prison. Most prison officials believe that illicit drug dealing and use represent one of the most serious prison problems. Providing MMT to inmates would apparently help with this problem by reducing drug activity.

Testosterone and Methadone Treatment by Beth Miller (ARM Rhode Island Chapter Director)

Low testosterone (T) is caused by many different factors, but those of us on MMT really need to know the facts and, if applicable, get a blood test done to check levels. This can affect both male and female MMT patients, but most physicians are unwilling to treat a woman with testosterone, as most testosterone replacement therapies (TRT) are only designed for men.

Though it can affect women, men are usually affected much more severely by low T. The following are possible symptoms of low T [some or all symptoms may exist]: low libido, less penile rigidity, loss of morning or spontaneous erection, loss of body hair, usually in patches on legs, arms and/or wrists, ingrown hairs, loss of muscle mass, central weight gain (stomach), fatigue, depression, anger, and irritability. Not only does low testosterone cause symptoms that you can notice but it can cause other undesirable effects such as osteoporosis, weak/brittle bones, and loss of lean body mass.

Male MMT patients suffering from sexual dysfunction face additional hurdles when seeking treatment, because not many research studies on MMT and sexual dysfunction exists, and many physicians know little about MMT in general. Often, physicians will not make the connection between sexual dysfunction and MMT at all, and therefore, they have little idea what to look for, and if they discover a problem like low T may insist on searching for a cause other than MMT. Instead of writing out all of the scenarios that could occur, I am going to write one young man's "journey" to get his testosterone therapy while on MMT.

CHAD'S FORAY INTO THE WORLD OF TESTOSTERONE THERAPY. Chad is a 33-year-old man who has been on methadone maintenance for four years at an average dose of 155 mg. For the past three years, Chad has had many symptoms of low T. These symptoms have sent him to many different doctors, as he was never informed that MMT can lower testosterone in men.

It started just about the time of his one-year anniversary on MMT. He had been free of all illicit drugs for almost one full year and took no other medication but his daily methadone dose. He began noticing that in the winter he was losing hair in patches on his thighs, calves, and one wrist. He went to his primary care doctor who did some blood tests, and they all came back fine. The doctor then referred him to a dermatologist for the hair loss, and the dermatologist could not find any reason for it. Chad went searching the Internet and found nothing—a lot of head hair loss but none on the body. He let it go, and for the next three years, to his dismay, every winter he would lose the hair on his legs and wrist.

The next symptom he noticed was that he had almost no sex drive/libido--this coming from a 30-year-old man who had an excellent sexual relationship with his wife of five years, so it really concerned him--everything worked fine, but the desire was gone, as were morning erections. He went to another doctor, which gave him Viagra(tm). But Viagra did not work for his problem because it is not designed to enhance desire; rather, it is made to help keep an erection, and that was not the issue with Chad.

Next he noticed on his face, which was always clear, he was getting ingrown hairs that first turned into infections, then into pimples. They were painful, so again he looked up what this could be a symptom of and found nothing. He dealt with this for almost three years.

He then began noticing that he was getting very irritable, jumping on his wife for little insignificant things and not having nearly as much patience with his two young children--this coming from a man who had tons of patience and loved to play with his children.

Then, his wife decided to go on the Internet and see what the symptoms of low testosterone were. When she found it, they almost CRIED! He had almost every single symptom. She hugged him and said, "you have to get to a doctor NOW!"

Finally, after three years of low sexual desire and a strain on his marriage, he got an appointment with a urologist. At the first appointment the doctor did an exam, which he was not crazy about but went through with it thinking, "finally, I will get the testosterone I need."

Note: Chad made the decision not to tell his urologist that he was presently taking methadone and had been for the past three years. This is NOT recommended, and it is one of the reasons that it took so long to get treated.

Well, the urologist sent Chad for blood tests to measure his level of testosterone, never thinking it would come back with the results it did.

The doctor called two days later and said "Chad, your testosterone is off the charts low; I need you to come in for some more tests." He then sent Chad for a test of his pituitary gland, a pea-sized gland in the base of the skull which regulates male sex hormones. Chad took the blood test, and it came back with extremely low LH and FSH levels. LH are Lutenizing hormones and FSH are Follicle Stimulating Hormones, (hence the loss of hair on the body and the ingrown hairs on the face). The doctor then called and wanted MORE tests. This was over three weeks after the first visit, and Chad had still not gotten any testosterone treatment, so by this time he was getting rather (**Cont. p. 3**)

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