

6 Facts about Methadone Treatment

1 Saves lives. Untreated opioid addicts have a death rate three to four times greater than patients in methadone treatment (*Methadone Associated Mortality: Report of a National Assessment*. Rockville, MD: Center for Substance Abuse Treatment; *NIH Consensus Statement*. National Institutes of Health).

2 Reduces transmission of HIV (four – six fold reductions), Hepatitis B and C, and other infections, which in turn decrease medical costs.

3 Eliminates or reduces illicit opiate use (by minimizing narcotic craving and blocking the euphoric effects of other narcotics).

4 Enhances productive behavior via employment and academic, vocational, and social functioning. Behavior change is evidenced in improved family and other social relationships, increased employment, improved parenting, etc., according to the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1994 and Lowinson JH et al. *Substance Abuse: A Comprehensive Textbook*. 2d ed. Baltimore, MD: Williams and Wilkins; 1992:552.

5 Reduces criminal activity. The most detailed study of treatment outcomes

to date (Ball JC, Ross A. *The Effectiveness of Methadone Maintenance Treatment*. New York: Springer-Verlag; 1991) showed that during the first four months of treatment, crime decreased from 237 crime days per year per 100 addicted persons during an average year of their addiction, to 69 crime days per year per 100 patients, a reduction of more than 70 percent (p. 205), declining further to only 14.5 crime days per year for patients in treatment six years or more.

6 Is cost effective. Methadone Maintenance Treatment (MMT), which costs on average \$4,000 per patient per year (Institute of Medicine: *NIDA Notes*), reduces the criminal behavior associated with illegal drug use, promotes health, and improves social productivity, all of which serve to reduce the societal costs of drug addiction. Cost benefit analyses indicate savings of \$4 – 5 in health and social costs for every dollar spent on MMT (*Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA): General Report*. Sacramento, CA: California Department of Alcohol and Drug Programs; 1994). Extensive evaluation studies show that methadone maintenance therapy reduces heroin use and associated problems in a cost-effective manner, without negative public health impact. Council on Scientific Affairs, American Medical Association, 2001.



*Myths
v. Reality*

Methadone Treatment

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Myths v. Reality

The benefits of methadone as a component of a comprehensive treatment program for opioid addiction have been validated by dozens of clinical studies and confirmed by numerous authorities in the addiction treatment field. Yet myths about methadone abound. The National Institute of Drug Abuse of the National Institutes of Health, the World Health Organization, and the Substance Abuse and Mental Health Services Administration, among many others, strongly support methadone treatment.



Myth 1 – Methadone just replaces one drug addiction with another.

Reality – Taking methadone medication as prescribed

by a physician is not an “addiction.” It is true that patients are physically dependent on it and do have withdrawal symptoms if the medication is abruptly stopped. However, that is true of many prescription medicines. Methadone does not cause impairment – it blocks opiate drug craving. The medication allows an individual to regain a normal state of mind, free of drug-induced highs and lows.

Myth 2 – Patients taking methadone are still “drug addicts.”

Reality – Patients in a methadone treatment program are not drug addicts. They are persons being treated for an addiction. The person taking the medication feels normal and withdrawal does not occur. When treated, behaviors are significantly different than when the individual was using heroin in terms of employment, family relationships, healthy living practices, involvement with the law, and overall individual wellness.

Myth 3 – Heroin addiction can be resolved without the use of medications if the person truly wants to change. Methadone is just a “crutch” for people who don’t want to work at recovery.

Reality – Long-term addiction to heroin or other opiates results in prolonged and, oftentimes, *permanent changes in the brain’s biochemistry*. It is that physical change in brain chemistry that results in cravings and depression that can go on for years and often results in repeated dangerous relapses. The desire to change does not fix brain biochemistry.

Myth 4 – Methadone from methadone clinics is flooding the streets.

Reality – The methadone on the street is principally from *prescriptions for pill form methadone written by pain clinic doctors* and filled at pharmacies, not the prescribed and monitored liquid form from methadone clinics. This has been documented by numerous studies including a 2009 Government Accountability Office study and a 2003 Center for Substance Abuse Treatment study.

Myth 5 – Methadone is the same as methamphetamine.

Reality – Methadone is a medication prescribed by a physician to assist in a patient’s recovery from addiction to opioids. Methamphetamine is a street drug and is a very addictive stimulant which can cause tremendous damage in addicted individuals.

Myth 6 – If methadone really was an effective approach there wouldn’t be so many people against it.

Reality – The Center for Substance Abuse Treatment (CSAT), The White House “Drug Czar,” the American Medical Association, the Association of Drug Courts, and other federal agencies without exception advocate for methadone treatment. There are no comparable organizations in opposition. In Pennsylvania, the Bureau of Drug and Alcohol Programs; the Institute for Research, Education, and Training in Addictions; the Office of Mental Health and Substance Abuse Services; the Division of Drug and Alcohol Program Licensure; the Pennsylvania Community Providers Association; the Pennsylvania Psychiatric Society; and other organizations strongly support the value of methadone treatment. Again, there are no comparable organizations in opposi-

tion. *Most of the opposition to methadone is based on an absence of factual information, misperception, and fear* – although some adverse events have occurred and close, medical monitoring is necessary.

Myth 7 – Methadone treatment should be limited and not continue for years.

Reality – Drug abuse is a brain disease. The length of time in treatment must be decided by a physician and the patient, as with any other medical treatment. Twelve months is the recommended minimum. Given that opiate addiction is a brain-related medical disorder, some opiate-dependent individuals will continue to benefit from this treatment for years. Patients sometimes require methadone treatment indefinitely, as would be expected with any chronic medical condition.

Myth 8 – Methadone from clinics is causing a rise in deaths.

Reality – Methadone-related deaths are associated primarily to the diversion of *methadone prescriptions for pain* (rather than from methadone used as a treatment for addiction) or illegally diverted from methadone clinics/patients. Methadone for the treatment of addiction is a liquid form. Methadone from prescriptions for pain is a pill form and much more likely to be diverted. The Drug Enforcement Administration (DEA) sets the annual production quota for methadone. From 1998 to 2006 the 250 percent increase in use is primarily associated with the use of methadone in pain management rather than addiction treatment (*DEA web site*).

