Methadone Maintenance Myths and Resources

Methadone maintenance has been used in the United States for approximately 50 years as an effective treatment for opioid addiction/dependence. Yet many myths about its use persist, discouraging consumers from benefiting from methadone, and leading family members, law enforcement, family service organizations, and other supports, to pressure individuals participating in treatment to stop. The most common concern is the thinking that the clinic setting is for **only** dosing the consumer with methadone. The clinic/clinical settings are Opioid Treatment Programs (OTP) and they serve as comprehensive treatment settings addressing the medical bio/psycho/social needs of each consumer.

As the need for the treatment of opioid dependence has grown, the federal government has developed guidelines that safeguard the proper use of both medication and clinical services, and firm practices to provide a secure atmosphere for substance-use disorders. The Federal Guidelines for the Accreditation of Opioid Treatment Programs require reliable and safe environments for the provision of a range of services such as individual and group counseling, family assistance in the recovery process, community support, medication-assisted recovery services, and attention to psychiatric conditions.

In an attempt to reduce countless impressions that promote stigma against the treatment of substance use disorders with methadone maintenance treatment (MMT), below are some of the more common myths about methadone and explanations as to why they are incorrect:

MYTH: Methadone is a substitute for heroin or prescription opioids: Methadone is a treatment for opioid addiction/dependence, not a substitute for heroin. **Methadone** is a long-acting **medication**, requiring a daily dose. **Heroin** is a short-acting, illegal, physically harmful **drug**, and generally takes using the drug at least three to four times daily to prevent withdrawal symptoms from emerging. As indicated in the bold and green lettering, it is important to use the proper vernacular otherwise it is very simple to assume that methadone is a drug such as heroin is a drug; therefore creating the perception that methadone is a substitute for heroin.

MYTH: Consumers who are prescribed a stable dose of methadone are addicted to the methadone: Consumers taking methadone are physically dependent on it, but not addicted to it. Methadone does not cause harm; rather, it provides benefits. People with many common chronic illnesses are physically dependent on their medication to keep them well, such as insulin for diabetes, inhalers for asthma and blood pressure pills for hypertension. ***Addiction*** is a neurobiological disease that includes genetic, psychosocial, and environmental factors. It is characterized by one or more of the following behaviors:

- Poor control over drug use
- Compulsive drug use
- Continued use of a drug despite physical, mental and/or social harm
- A craving for the drug
- General changes in moods and behaviors

Physical dependence is the body's adaptation to a particular medication. The individual's body becomes used to receiving regular amounts of a certain medication. When the medication is abruptly stopped or the dosage is reduced too quickly, the person will experience withdrawal symptoms.

MYTH: Patients who are stable on their methadone dose are not able to perform well in many jobs: People who are stable on methadone should be able to do any job they are otherwise qualified to do. A person stabilized on the correct dose is not sedated, in withdrawal or euphoric. The most common description of how a person feels on methadone is "normal."

MYTH: Methadone rots teeth and bones: After 50 years of use, methadone remains a safe medication. There are side effects from taking methadone and other opioids, such as constipation and increased sweating. These are usually easily manageable. If patients engage in good dental hygiene, they should not have any dental problems.

MYTH: Methadone is not advisable in pregnant women: The evidence over the years has shown that a pregnant woman addicted to opioids has the best possible outcome for herself and her fetus if she receives methadone maintenance therapy. A pregnancy's outcomes are better for mother and newborn if the mother remains on methadone than if she tapers off and attempts to be abstinent during pregnancy. Methadone does not cause any abnormalities in the fetus and is not linked to the cause of cognitive or any other abnormalities in these children as they grow up. Babies born to mothers taking methadone will experience neonatal abstinence syndrome, which occurs in most newborns whose mothers were taking opioids during pregnancy. This syndrome is treated and managed somewhat easily and outcomes for the newborn are good—it is not a reason for a pregnant woman to avoid methadone treatment. Mothers on methadone should breastfeed unless there is some other contraindication, such as being HIV-positive. Breastfeeding an infant can assist a child with the discomfort of neonatal abstinence syndrome because the infant receives small amounts of methadone through the breast milk.

MYTH: Methadone makes you sterile: This is untrue. Methadone may lower serum testosterone in men, but this problem is easily diagnosed and treated.

These myths, and the stigma of methadone treatment that accompanies them, are pervasive and persistent issues for methadone patients. They are often embarrassed to tell their other physicians, social supports, employers and family members about their treatment. They may feel they are doing something wrong, when in fact they are doing something very positive for themselves and their loved ones. These misperceptions can only be corrected with more education for consumers, families, legal system representatives, health care providers and the general public.

The use of MMT during pregnancy has been proven to be the most effective manner in the treatment of a pregnant and opiate dependent individual. Many fabrications surround the effects of methadone on both an unborn child and a newborn. Below are several myths in circulation followed by correct information:

Misconceptions about Methadone Use during Pregnancy:

Methadone is a synthetic opioid that can suppress drug cravings and prevent drug withdrawal syndromes, keeping both the mother and baby safe for the duration of the pregnancy. Methadone can be used during any stage of pregnancy, and should only be administered under close medical supervision at an opioid treatment program or residential support program for substance-use disorders.

Many women may hesitate to use methadone during pregnancy, believing they are substituting one drug for another. The effects of methadone are much less damaging to a baby than many think.

Here are five misconceptions people have about using methadone during pregnancy:

Misconception 1. The baby will be born with birth defects or experience developmental problems:

Mothers may be concerned that their children will have learning disabilities, Attention Deficit Hyperactivity Disorder, decreased intellect or other disorders as a result of being exposed to methadone in utero. But there is no scientific evidence of any such negative effects on babies exposed to methadone. In fact, long-term studies have shown no significant effects on babies whose mothers use methadone while pregnant.

For those babies born with birth defects or developmental problems, the drug their mother was addicted to is likely to blame. The most critical period of development for a fetus is during the first trimester, and many women don't realize they are pregnant at that point. For women addicted to drugs, that means they are still using and engaging in high-risk behaviors during this time, exposing their baby to drugs and their dangerous effects.

By the time pregnant women seek methadone treatment, they are usually in their second trimester, which is the safest time to administer the treatment.

Misconception 2. The baby will become addicted to methadone:

Babies cannot become addicted to methadone. Because babies are unaware that they are being treated with methadone, they cannot develop anything more than a physical dependence to the medication. While the baby will likely experience some mild discomfort during the detoxification process, they will never remember being given the medication.

Misconception 3. The baby will suffer during methadone withdrawal:

When a pregnant woman ingests methadone, so does her baby. And, like an adult who has undergone methadone treatment, the baby may need to go through detoxification and withdrawal from the medication. While withdrawal is never a pleasant experience, doing so in a controlled environment, such as in a hospital, can provide comfort to the newborn.

Babies whose mothers are addicted to drugs or are prescribed methadone will likely experience neonatal withdrawal syndrome upon birth. Symptoms of the syndrome include rapid breathing, excessive crying, increased muscle tone, sneezing, yawning and gastrointestinal issues.

To ease the symptoms, and to more effectively wean babies off of methadone, the treating hospital will stabilize and begin to wean the infant then by providing a medication such as morphine. Morphine is a short-acting drug that allows babies to be more easily weaned off methadone in about two to three weeks. A stabilized newborn can return home with his/her mother and be provided the medication in the home environment if a period of hospitalization is not recommended.

Misconception 4. The higher the dosage of methadone, the worse the baby's withdrawal symptoms:

There is no relationship between the strength of the methadone dosage and the severity of an infant's withdrawal symptoms. Because each person requires a distinctive dose of methadone, the determining factor is methadone's effect on that particular baby.

The goal of methadone is to allow the woman to have an easier time during pregnancy and lessened withdrawal symptoms and drug cravings herself. That may mean upping the dosage as the pregnancy progresses, but women should be aware that that alone will have no effect on her baby's withdrawal experience.

Misconception 5. It is okay to quit methadone "cold turkey":

Of course, the best way to ensure a healthy baby and pregnancy is to not use any drugs at all. But for women who are being treated with methadone to address a more damaging drug addiction, the absolute worst thing they can do is to reduce their dosage or stop use completely. Doing so can induce withdrawal symptoms in the baby and cause an unintended abortion.

Methadone can be used throughout pregnancy, and should be used for as long as the mother feels it is necessary. Through the support of medical staff and therapists at an opioid treatment program or residential support treatment program, women who gave birth can eventually choose a methadone tapering schedule and complete a medically supervised withdrawal under the care of a physician.

Here are several links and attachments to some principled and advantageous information concerning neonatal withdrawal and Methadone Maintenance Treatment (MMT):

Newborn Withdrawal Project:

http://dcf.wisconsin.gov/children/foster/permanency_roundtables/pdf/neonatal_abstinence_syndrome_%20guide.pdf.

Medication Assisted Treatment during Pregnancy, Postnatal and Beyond:

http://www.cffutures.org/presentations/webinars/medication-assisted-treatment-during-

pregnancy-postnatal-and-beyond.

Neonate Opiate Withdrawal:

http://www.clinicaladvisor.com/neonate-opiate-withdrawal/article/136834/.

Medication-Assisted Treatment – Links to Anti-Discrimination Information:

Educating Courts, Other Government Agencies and Employers About Methadone and Helpful Resources to Address Discrimination Against People in Medication-Assisted Treatment (2009) - This publication explains how individuals in methadone maintenance programs and other forms of Medication Assisted Treatment, as well as their treatment programs and advocates, can advocate for their rights so that they can get in or stay in the treatment they need – without discrimination. The focus is on discrimination by the child welfare system and criminal justice system – including driving under the influence, jails and prisons, education of employers and probation and parole.

Know Your Rights: Are You in Recovery from Alcohol or Drug Problems? Rights for Individuals on Medication-Assisted Treatment (2009) - This brochure is a companion piece to ***Know Your Rights: Are You in Recovery from Alcohol or Drug Problems?*** Provides descriptions of the specific legal issues faced by people in Medication-Assisted Treatment for opiate addiction. (Funded by Partners for Recovery, an initiative of the Center for Substance Abuse Treatment of the U.S. Department of Health and Human Services).

Know Your Rights – Training Materials - The Legal Action Center has conducted numerous Know Your Rights trainings across the country for people in the recovery and their allies. Funded by the Partners for Recovery Initiative of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), these trainings cover anti-discrimination laws that protect individuals with alcohol and drug problems from discrimination in employment, housing, and elsewhere. They also cover anti-discrimination protections for individuals who also have a criminal record.

Legality of Denying Access to Medication Assisted Treatment in the Criminal Justice System (2011) - This is a report that explains why criminal justice agencies violate Federal anti-discrimination laws and the United States Constitution when they deny access to medications, such as methadone and buprenorphine, to treat opiate addiction. The report was written at the request of the American Association for the Treatment of Opioid Dependence (AATOD), who has a longstanding interest in expanding the use of these medications in criminal justice settings.

Cognitive Function in Opioid Substitution Treated Patients (2014) - https://www.julkari.fi/bitstream/handle/10024/116171/URN_ISBN_978-952-302-224-9.pdf?sequence=1.

Methadone Maintenance Treatment: Memorandum of Driving & Psychomotor Studies and Background Information about Methadone Treatment (April 2000) - This packet of information contains a memorandum summarizing recent literature and studies about the effect of methadone treatment on patients' driving ability as well as psychomotor and intellectual functioning, the actual articles and studies referenced in the memorandum, and

background information about methadone treatment. A useful resource for people trying to combat discrimination based on participation in methadone maintenance treatment.

Ten Things You Should Know About Methadone:
http://www.recoveryhelpdesk.com/2010/02/07/series-10-things-you-should-know-about-methadone-number-5/.

Additional Resources:

- http://www.opiate.com/methadone-maintenance/.
- http://www.samhsa.gov/medication-assisted-treatment.
- https://www.drugpolicy.org/docUploads/meth347.pdf. (Interesting plus history of MMT)
- http://store.samhsa.gov/shin/content//PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf. (New Federal Guidelines for Opioid Treatment Programs as of 03.27.2015)