

Dear Family member or Friend;

This letter will attempt to address some common concerns of those of you who have loved ones on MMT (methadone maintenance treatment). There are many misconceptions and common misunderstandings surrounding this treatment, which education and knowledge about the treatment may alleviate. Methadone, unfortunately, is surrounded by unfair stigma and prejudice based on fears and assumptions, not science and medicine. Family members quite naturally are concerned about their loved one's health and future and want the best for them, and they may have heard some things about MMT that cause them alarm.

One of the most commonly voiced concerns is that MMT is "just trading one addiction for another". Many feel that the only way to truly recover from addiction is to abstain from all mood altering substances. At one time this was thought by most to be true. However, science has discovered that with long term opiate addiction (opiates meaning heroin, vicodin, morphine, oxycontin, etc), the brain's natural production of endorphins is shut down. Endorphins are the chemicals we all have that enable us to feel pleasure and happiness. We all have opiate receptors in our brains for these chemicals to attach to. The word "endorphin" comes from "endogenous", meaning coming from within, and "morphine"--i.e., morphine from within. These chemicals are released when we eat delicious food, make love, enjoy a beautiful sunset, exercise (runner's high), or even when we are injured, as natural painkillers. Without this natural chemical, life can be very difficult and painful.

When we flood our systems with exogenous (outside) opiates, our bodies recognize that we have plenty on board and cease to manufacture our own natural endorphins. This results in the patient feeling extremely ill when withdrawing from opiates. They experience depression, irritability, exhaustion, anger, sleeplessness, hopelessness, etc. This happens to all opiate abusers when they cease taking opiates and is to be expected. Some patients, especially those with short term addiction histories, will be able, after a few weeks or months of abstinence, to get their natural endorphins back into good working order again, and will begin to gradually improve. However, for many, the damage done is permanent. This has been demonstrated in many scientific studies involving CT scans of the addicted brain. For these patients, no amount of abstinence, group therapy, meetings, will power, or good intentions will undo the fact that their brains simply will no longer produce endorphins in sufficient

quantity to enable them to live a normal, happy life. This is, in fact, very similar to the way in which diabetics require supplemental insulin because their pancreas no longer manufactures insulin. In addition, there are some patients who have never had a normally functioning endorphin system, who have struggled since birth with crippling depression, and who became addicts in an effort to relieve their constant emotional and mental misery. For them, too, abstinent recovery works poorly or not at all. This is where MMT comes in.

Methadone is a synthetic (man made) opioid drug, used to treat pain and addiction. It has some unusual properties that make it well suited to addiction treatment. It is a long acting drug, remaining active in the tissues for up to 72 hours after ingestion. It does not cause the high or euphoria caused by other, short acting opiates because it is taken up gradually by the brain, not suddenly and sharply. In fact, many overdoses involving this drug are due to people seeking the high they have come to expect with other opiates and not getting it, so they take more and more. A stable methadone patient who is not mixing the medication with other drugs--particularly benzodiazepines, which can sometimes be a very dangerous mixture-- and who is on a medically appropriate dose will not be "high" or sedated. These patients are able to work, operate a vehicle, care for children, and do anything else a normal person can do. Their minds are not "clouded". Some of these rumors may come from observing patients who are abusing other drugs, or are taking more than prescribed.

Methadone, properly administered and taken, balances the chemicals in the brain so that the patient feels normal. Unfortunately, standard antidepressants generally do not work well for those with dysfunctional endorphin systems because they target serotonin, not endorphins.

Methadone is also unique in that it does not attach to all the opiate receptors in the brain, leaving some open to encourage production of natural endorphins if possible. This may contribute to the healing of the addicted brain. Methadone is commonly referred to as "replacement" or "substitution" therapy, and most think that this means it is replacing the heroin, etc that the patient was abusing, when in fact, it is replacing the natural endorphins no longer being manufactured by the patient's brain, in the same way synthetic insulin substitutes for that not being made by the diabetic's own organs. Methadone treatment enables the patient to return to a normal, productive, law abiding life in a great many cases, and

even when the patient continues abusing other drugs, etc, it may lower their chances of contracting a disease by reducing their drug use, and enables them to see a medical professional for assistance and referrals on a daily basis.

However, for many (not all) MMT patients, long term therapy--even life long--may be needed to maintain recovery. Addiction is a chronic, incurable disease. We do not tell diabetics, blood pressure patients, and epileptics to discontinue their medications because we know that if they do, the active disease will return. Why, then, do we encourage recovering, thriving MMT patients to do so, when the relapse rates for those discontinuing MMT is greater than 90%? Methadone is the most effective modality of treatment for opiate addiction available today--far more effective than traditional rehabs and 12 step groups alone. By no means is it the treatment of choice for every opiate addict--however, if abstinent methods have failed many times over, there is little point in continuing to try the same thing expecting different results "this time".

Most experts recommend that a patient remain in MMT a MINIMUM of 3 years after they cease illicit drug use. At that time, if, and only if, the PATIENT themselves wishes to begin a taper program, one can be attempted. Tapering must be done on a slow and gradual basis--no more than 10% of the dose every 2 weeks to a month. If the person begins experiencing severe cravings or withdrawals, they should stop and return to an adequate dose until symptoms subside. If the person relapses, this should not be seen as failure or weakness, but only as evidence that they may require ongoing therapy to control their symptoms. Family support is ESSENTIAL to the patient's successful recovery on MMT, and continued questions of "When are you going to get off that stuff? It's just a crutch!", etc undermine treatment efforts and sabotage recovery, leaving the patient confused, sad and frustrated instead of feeling proud and happy at the improvements in their lives. Addiction is a deadly disease and there are few effective treatments for it, so please support your loved one's recovery efforts and praise them when you see improvements. There is nothing positive to be gained by forcing them off treatment before they are ready.

If you would like more information about MMT, please seek out reputable sources such as WWW.SAMHSA.Gov, the American Assoc. for the Treatment of Opioid Disorders (AATOD) website, the White House Office of Drug Policy, etc.