The Effective and Responsible Use of Medication Assisted Treatment (MAT) White Paper

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Position Statement

The Regional Mental Health Coalition of Northeast Indiana (Regional Coalition), a multidisciplinary advocacy body serving 10 northeast Indiana counties, consists of area mental health providers, criminal justice professionals and community mental health advocates who are dedicated to improving mental and behavioral health and wellness, including substance abuse treatment, prescribing habits of prescription opioid medications and reducing stigma through community awareness and education. The purpose of this paper is to clearly state the Regional Coalition’s position on the utilization of medication-assisted treatment (MAT) for opioid use disorders (OUD) and identify the best evidence-based treatment recommendations when treating OUD.

Summary of the problem

Every 12 minutes a person in the United States dies from an opioid overdose. 1 11.4 million people aged 12 and older misused an opioid in 2017 and over 2 million met criteria for an opioid use disorder. Over 2 million people-initiated use of opioids including heroin in 2017. 2 The annual cost of the opioid epidemic was $78 billion in 2013; of that, only 3.6% was spent on treatment. 3 Indiana has an opioid overdose death rate of 12.6 per 100,000 in 2016, an increase of 48.2% over the previous year. 4 In 2017, Allen County, the largest and most populace county in Northeast Indiana, had 127 accidental drug overdose deaths, an increase of more than 70% from 2016. 5 The exponential increase in mortality rates due to opioids and number of at-risk persons for OUD in our area has led to state and local officials proclaiming that Northeast Indiana has an “opioid epidemic”. 1
The Regional Coalition believes that substance use disorders (SUD) including opioid use disorders (OUD) are a chronic disease and like other chronic diseases, such as diabetes and heart disease, can be treated medically and successfully managed. Additionally, the Regional Coalition believes that treatment with Food and Drug Administration (FDA) approved medications in combination with evidence-based psychosocial and behavioral therapies are the most effective form of treatment. Unfortunately, several barriers exist that limit the implementation and utilization of treatment. The National Institute on Drug Abuse (NIDA) reports only 11% of those who were diagnosed with a moderate to severe OUD were prescribed medication in 2017. Blue Cross reports that there was a 493% increase in members diagnosed with OUD but only a 65% increase in the use of medications to treat OUD. These barriers are very evident in Northeast Indiana. In Allen County, less than 3% of those diagnosed with an OUD are treated with medications and in the surrounding nine rural counties of Northeast Indiana the rate is only 1.1%.

Evidence for MAT

In treating opioid use disorder, evidence shows that current FDA approved pharmacological therapies such as Methadone, Buprenorphine and Naltrexone are highly effective in helping people overcome opioid dependency. MAT can alleviate cravings, significantly decrease withdrawal symptoms and block and/or minimize the effects of opioids in the event of relapse. Several well-designed studies conclude that MAT lowers the risk of overdose death 50% to 79%. Other reputable studies showed engagement into treatment and duration of treatment were significantly increased when clients were on MAT. The data demonstrated that engagement into treatment was increased 40% to 60% for those on MAT and clients stayed in therapy up to 50% longer and were less likely to atypically discharge from treatment when on MAT than those untreated. MAT helps adjust the chemical imbalances in the brain created by the addiction by “calming the brain” from the cravings and withdrawal symptoms associated with the disease, thus allowing the person to more fully engage and benefit from treatment and reclaim their lives. MAT is best delivered by following evidence-based guidelines such as those provided by the American Society of Addiction Medicine (ASAM) or the Substance Abuse and Mental Health Services Administration (SAMHSA).

Another important aspect to acknowledge is that evidence-based therapeutic programs, such as 12 Step Facilitation, by themselves are useful interventions for successfully treating OUD/SUD. However, the success rates of absence-based OUD programs are much lower than programs where evidence-based therapeutic interventions and MAT are combined. The best course of treatment should be individualized and always be an informed clinical-based decision between the treatment provider(s) and the client.

The Regional Coalition also recognizes there is evidence to suggest that FDA approved medications for OUD alone, without therapeutic interventions, will decrease fatal overdose death and can be an effective harm reduction strategy. The Regional Coalition also recognizes there are some published studies suggesting there are “no added benefits” to adding therapeutic
interventions to MAT. However, after closer scrutiny, it is the opinion of the Regional Coalition that most of the studies that suggest therapeutic interventions are not effective have serious design flaws that potentially skewed the results. Many of the conflicting studies did not use evidence-based therapeutic interventions in the study design and most did not require persons to complete the full course of a therapeutic program as part of the study. Furthermore, most of the subjects in these studies where treated in a primary care setting and thus, had very low severity of illness and lacked co-morbidities. More often than not, the more complex and severe clients, who would most likely benefit from therapy, were excluded from these studies. There are several well-designed published studies that demonstrate long-term improved efficacy with MAT when it is combined with therapy. The best nationally recognized treatment programs view MAT as “assisting” other needed components of treatment and require evidence-based therapeutic interventions to be an essential component of treatment. The Regional Coalition strongly recommends that MAT be used in combination with evidence-based therapeutic interventions and/or evidence-based curriculum. In conclusion, the Regional Coalition believes combining MAT with evidence-based therapies has proven to significantly increase the possibility of long term sobriety, improve other health conditions, enhance socioeconomic status, lower overall community health care costs, decrease crime, restore relationships and reduce the transmission of infectious diseases such as HIV and hepatitis C.

### Comparison of Medications for OUD

<table>
<thead>
<tr>
<th>Prescribing Considerations</th>
<th>Methadone</th>
<th>Buprenorphine</th>
<th>Naltrexone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism</td>
<td>Agonist</td>
<td>Partial Agonist</td>
<td>Antagonist</td>
</tr>
<tr>
<td>Phase of Treatment</td>
<td>MSW, maintenance</td>
<td>MSW, maintenance</td>
<td>Prevention of return to opioid use following MSW</td>
</tr>
<tr>
<td>Route of Administration</td>
<td>Oral</td>
<td>Sublingual, subdermal implant*, subcutaneous extended release#</td>
<td>Oral, intramuscular</td>
</tr>
<tr>
<td>Regulations and Availability</td>
<td>Schedule II, opioid treatment programs (OTP) or acute care hospital setting</td>
<td>Schedule III, OTP or waivered physicians in office or ED setting</td>
<td>Not scheduled; requires prescription</td>
</tr>
</tbody>
</table>

* Prescribers must be certified by Probuphine (Buprenorphine implant) Risk Evaluation and Mitigation Strategy (REMS) Program, special training required for placement and removal.

# Healthcare settings and pharmacies must be certified in Sublocade (Buprenorphine subq injectable) REMS and only distribute medication directly to a provider.
### Evidence-Based Therapeutic Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Cognitive Behavioral Therapy (CBT)</strong></td>
<td>Challenges irrational thinking processes and identifies how to correct them, enhancing self-control through coping strategies.</td>
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<tr>
<td><strong>Motivational Enhancement Therapy (MET)</strong></td>
<td>Addresses barriers in the client’s motivation to change from maladaptive behaviors; elicits rapid and internally motivated change; focuses on empathic communication.</td>
</tr>
<tr>
<td><strong>Twelve Step Facilitation (TSF)</strong></td>
<td>Promotes abstinence through facilitating client engagement with Twelve Step fellowship groups; teaching the concepts of acceptance, surrender to a Higher Power and the importance of helping others.</td>
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<tr>
<td><strong>Community Reinforcement</strong></td>
<td>Eliminates positive reinforcement for using drugs while increasing positive reinforcement for abstinence; teaching new coping behaviors for high risk situations; focusing on involving significant others in the recovery process.</td>
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<tr>
<td><strong>Contingency Management</strong></td>
<td>Grounded in Learning Theory, involves applying nondrug-related reinforcers to increase abstinence.</td>
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### Barriers to Treatment

There are several barriers to MAT and best practice, evidence-based treatment:

1. Across the nation people in need of MAT treatment far exceeds the provider capacity to treat them. Only 23% of publicly funded treatment programs and less than 50% of private treatment programs offer MAT. Even in programs that offer MAT, only 34.4% of patients receive it.¹⁶
2. 53% of U.S. counties do not have a data waived physician to prescribe MAT. Even in areas where MAT is available, most MAT is provided with very limited or without any evidence based psychosocial and behavioral therapeutic interventions.³
3. Most physicians and advanced practice providers have had little formal training in treating OUD and thus, do not feel comfortable managing OUD or SUD clients. Becoming a MAT provider requires 8 hours or more of additional training to obtain a waiver. Physicians complain they often do not have time to do the necessary training.
4. Many prescribers fear they are inviting the scrutiny of the Drug Enforcement Agency (DEA) if they start prescribing MAT and don’t believe they have adequate places to refer should complications develop.
5. Stigma of the illness by lay persons in our communities, including many health professionals and some mental health professionals, has led to difficulty in accepting OUD/SUD as a chronic brain disease. These views are contrary to the latest scientific
findings and vicariously create significant negative attitudes toward those seeking or currently in treatment. Like other chronic diseases, OUD is a chronic condition that is characterized often by high relapse rates, is a life-long condition, and can be managed but is not cured by medication. Too often there is a wide gap between the latest neuroscience of OUD and actual clinical practice. For decades “abstinence only” based programs have dominated the treatment landscape. However, abstinence only based programs generally have much lower outcomes. Most abstinence programs, with no MAT, have a 10% successful sobriety rate after a year.\(^\text{18}\)

There are several myths associated with MAT, that some treatment providers still believe, that potentially prevent the willingness to initiate MAT treatment. The Regional Coalition believes it is paramount to promote the understanding of SUD/OUD as a biologically based, chronic medical disease.\(^\text{9,15,16,20,21,22}\)

Viewing OUD/SUD as a chronic brain disease changes how treatment is delivered and allows for medical interventions to be first line therapies. Similarly, as with other chronic diseases like diabetes and heart disease, medication(s) are accepted and proven as first line options for the management of the disease. Likewise, MAT should be first line therapy for the treatment of OUD.\(^\text{9,17}\)

<table>
<thead>
<tr>
<th>Myth</th>
<th>Reality</th>
<th>Possible Policy Response</th>
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<tr>
<td>Buprenorphine treatment is more dangerous than other chronic disease management</td>
<td>Buprenorphine is simpler than many other routine treatments in primary care, such as titrating insulin or starting anticoagulation. Physicians receive little or no training in MAT</td>
<td>Amend federal buprenorphine treatment eligibility requirements to include training completed during medical school and require training during medical school or residency. Add competency questions to U.S. Medical Licensing Examinations and other professional licensing exams.</td>
</tr>
<tr>
<td>Use of MAT is simply a “replacement” addiction where it is just replacing one dangerous drug for another and it can be easily diverted.</td>
<td>Addiction is defined as compulsively using a drug despite harm. Taking a prescription drug to manage a chronic illness does not meet that definition. MAT is very safe, significantly reduces overdose potential and substantially improves recovery rates. The overdose potential is very low.</td>
<td>Public health campaign to reduce stigma associated with addiction treatment, similar to past campaigns (e.g. HIV) that provided education and challenged common myths. Utilize drug testing, short term scripts and drug monitor techniques.</td>
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Detoxification for opioid use disorder is effective

There is no data showing that detoxification programs are effective at treating opioid use disorder. In fact, these interventions may increase the likelihood of overdose death by eliminating tolerance.

Advocacy from professional organizations to educate federal and state agencies and policymakers about evidence-based treatment and the lack of evidence for short term “detoxification” treatment. Mandate that insurance providers, Medicaid and Medicare pay for MAT and evidence-based therapeutic programming.

Reducing opioid prescribing alone will reduce overdose deaths.

Despite decreasing opioid prescribing, overdose mortality has increased. Patients with opioid use disorder may shift to the illicit drug market, where the risk of overdose is higher.

Develop a national or regional system of virtual consultation for providers to reach addiction and pain specialists who can support treatment of patients suspected of OUD. Develop alternative comprehensive programs to address pain.  

### MAT in pregnancy and neonatal abstinence syndrome (NAS)

Reproductive age women are at highest risk for substance use disorder, and pregnancy may be one of the few times they may present for treatment. The American College of Obstetrics and Gynecology’s (ACOG) current stance is that pregnant women who have opioid use disorder should be managed by an experienced provider.  

ACOG prefers MAT over medically assisted withdrawal due to the higher risk of relapse (59-90%).  

There is emerging evidence to suggest that medically assisted withdrawal may not increase the risk of fetal stress, preterm birth and pregnancy loss as previously thought; however, since studies have shown relapse rates as high as 90%, this is not currently preferred.

Medications which can be used include methadone and buprenorphine. Methadone treatment during pregnancy continues to require daily dosing. In some instances, methadone dosing may need to be increased, especially during the third trimester, due to the potential for significantly increased metabolism.  

Minimizing the dose is not recommended as an association of dosage and the likelihood and severity of withdrawal symptoms has not been found in multiple studies.  

Buprenorphine offers less need for dose adjusting during pregnancy, and lower likelihood of symptomatic opioid withdrawal.  


Based on distinct advantages and disadvantages of each medication, a treatment plan should be individualized to each patient’s specific needs.
Infants born to women using medication assisted therapy are at risk of withdrawal. These infants should be managed by an experienced pediatric provider. Non-pharmacologic care should be initiated quickly after delivery. The American Academy of Pediatrics encourages a non-judgmental approach when addressing these families. Non-pharmacologic care is inexpensive. It should be initiated in the forms of skin to skin/kangaroo care with the mother, breast feeding when there is no concern of polysubstance or illegal substance use, a low stimulation environment (low noise, low lighting), frequent or on-demand feedings and holding, cuddling and swaddling. Methadone and buprenorphine are safe in breastfeeding. All of these non-pharmacologic therapies can decrease the need for pharmacologic treatments in infants, and thus shorten their hospital stay.

**MAT initiation**

The Regional Mental Health Coalition of Northeast Indiana recognizes there are several factors to consider prior to initiating OUD treatment, including the initiation of MAT.

Recommendations for treatment should be made after an intense, individualized assessment has been performed by qualified professionals. There are also many factors that can influence the treatment regimen and overall length of treatment, those include: drug abuse patterns, past treatment experiences, relapse history, family and peer support, level of care needed, recovery prognosis, financial feasibility, insurance coverage, living arrangements, employment factors, and client preferences. Clients should be educated on the risk and benefits of MAT and the decision to initiate MAT should be a collaborative effort with the client and the professional treatment provider or treatment team.

Likewise, the choice of the most appropriate MAT medication to be initiated should be based on a comprehensive consultation of these factors with the client. The duration of MAT should also be individualized to support the goal of life-long recovery and remission of the disease. Although the goal should always be working toward discontinuation of MAT altogether, the Regional Coalition recognizes there may be a small subset of individuals that need to be on MAT indefinitely. The Regional Coalition strongly views MAT, when combined with evidence based therapeutic interventions, as the most effective course of treatment of OUD/SUD. Clients are encouraged to actively participate and successfully complete an evidence-based therapeutic treatment program and engage in support groups as part of their overall plan for life long sobriety.
Recommendations

The following main points are best practice recommendations from the Regional Mental Health Coalition of Northeast Indiana for the treatment of Substance Use Disorder. Providers who treat patients for Opioid Use Disorders (OUD) should also screen for co-occurring mental health conditions as well as other SUD including tobacco and alcohol. Effective care collaboration and care coordination within a community is essential for effective treatment and long-term support.

Whereas

Addiction is a chronic, treatable disease requiring continuing care rather than episodic, acute care treatment.

We believe:

- Opioid Use Disorders should be viewed as a chronic brain disease that can be medically treated and medically managed.
- Stigma concerning addictions and myths related to MAT should be proactively confronted and ongoing education about OUD should occur with healthcare professionals, the criminal justice system, the Department of Child Services, OUD affected families and the community at large.
- Public and private insurers should cover MAT medications, doses and formulations.
- Public and private insurers should cover medically-necessary mental health evidence-based therapeutic interventions at all levels of the continuum (inpatient, outpatient, peer support, and residential services) for OUD and SUD.
- Private insurers should design plans to include OUD and SUD screenings under preventive care benefits.
- Financial qualifications for Medicaid for pregnant moms should be increased to 200% of federal poverty to assure that lower income families who have private insurance have a second source of payment, to cover deductibles and other out-of-pocket expenses.
- MAT and addiction management should be integrated into medical school, advanced practice providers (APP) curriculum and master’s level mental health and social work programs.
- Providers of OUD therapy should be licensed in a mental health field and/or have relevant ongoing certification and specific training in OUD.

Whereas

OUD medications reduce illicit opioid use, retain people in treatment, and reduce the risk of opioid overdose death better than treatment without medications.
We believe:

- All patients diagnosed with an OUD should be evaluated for medication management. Medications for OUD should be integrated into all treatment settings including forensic diversion, residential, inpatient and outpatient programs.
- Prescribers should be encouraged to become data waivered and incentivized to manage OUD like other chronic diseases.
- Pregnant women with OUD can be safely treated with either buprenorphine or methadone; neonatal opioid withdrawal syndrome is a treatable condition with no identified long-term sequelae for the child.

Whereas

MAT is most effective to lifelong sobriety for OUD when combined with evidence-based therapeutic interventions and on-going support.

We believe:

- MAT is best delivered by following evidence-based guidelines such as those provided by ASAM or SAMHSA.
- MAT treatment should be individualized and should be based on a variety of factors, such as, drug abuse patterns, past treatment experiences, relapse history, family and peer support, level of care needed, recovery prognosis, financial feasibility, insurance coverage, living arrangements, employment factors, and client preferences, to support lifelong recovery and remission of the disease.
- OUD medications can be taken on a short- or long-term basis, including as part of medically supervised withdrawal and as maintenance treatment. The best results occur when the patient receives the medication as long as it provides a benefit.

Conclusion

Fatal overdose deaths along with the increasing numbers of individuals dependent upon opioids and other substances in Northeast Indiana have reached epidemic proportions. The societal, fiscal and human costs to our communities and families are devastating. There are effective FDA approved medications that have proven to reduce overdose rates and increase engagement and duration of treatment. Medication assisted treatment for OUD is most effective when delivered with evidence based therapeutic interventions. The greatest need to changing how care is delivered is to confront stigma and promote an understanding of addictions as a biologically based, chronic brain disease that can and should be treated with medical approaches.
Notes

5 Fort Wayne Allen County Task Force for Opioid Strategic Planning (FATOS): Turning Hope into Action. Evaluating the Opioid Crisis in Fort Wayne and Allen County. Prepared by the FATOS planning committee, The Lutheran Foundation and The Purdue University at Fort Wayne Community Research Institute, Director Rachel Blakeman JD, May 2018.
6 Marc R. Larochelle MD, MPH et al; Medication for Opioid Use Disorder after nonfatal Opioid Overdose and Association with Morality: A Cohort Study. Annals of Internal Medicine, August 2018.
8 Parkview Behavioral Health and Park Center Community Health internal regional prescription data analysis, June 2018.
14 Jane Liebschutz MD, MPH et al. Buprenorphine Treatment for Hospitalized, Opioid Dependent Patients: A Randomized Clinical Trial. JAMA Internal Medicine 2014, 1369-1376.
For more information on the Regional Mental Health Coalition of Northeast Indiana, visit LookUpIndiana.org/RMHC, or contact Kristina Johnson at kristina@thelutheranfoundation.org or 260-458-2112. Launched in 2016, The Regional Mental Health Coalition is an initiative of The Lutheran Foundation.