

# Medication-Assisted Treatment (MAT) for Opiate Dependence—It's Not “Giving Drugs to Drug Addicts”



*The Food and Drug Administration (FDA) has approved three medications for use in the treatment of opioid dependence: methadone, naltrexone, and buprenorphine.<sup>a</sup>*



With an array of medications now available for addressing the emerging prescription painkiller epidemic, it is crucial that providers in both primary and specialty care settings become trained in medication-assisted treatment (MAT), an approach that uses FDA-approved pharmacological treatments, often in combination with psychosocial treatments, for patients with opioid-use disorders (ONDCP, 2012).

More than 10 million people reported using prescription painkillers in 2012 (SAMHSA, 2012). Of these, an estimated 15% are opiate dependent and would benefit from treatment (SAMHSA, 2012). Nevertheless, MAT has been used in fewer than half of treatment facilities (Knudsen, Abraham, & Roman, 2011).



## ■ What Is MAT?

MAT is a corrective but not a curative treatment for opiate dependence. The most effective MATs to treat opiate dependence are methadone (Dolophine<sup>®</sup>, Methadose<sup>®</sup>) and buprenorphine (Suboxone<sup>®</sup>, Zubsolv<sup>®</sup>). These are among the drugs classified as opiates; treatment with these drugs is called *opiate replacement therapy (ORT)*. These are long-acting medications that, when taken as prescribed, do not get the person high. Like other opiates, they bind to the body's natural opiate receptors, but they are less addictive. Although they can be misused, when taken appropriately they help those in therapy feel normal and live normal lives.

Because methadone and buprenorphine are opiates, some people equate them to “giving drugs to drug addicts.” But this is not the case. These drugs relieve narcotic craving, prevent symptoms of opiate withdrawal, and block the euphoric effects associated with heroin and other more powerful narcotic medications (Joseph, Stancliff, & Langrod, 2000). The medications are usually prescribed on an ongoing basis, similar to taking a medication for high blood pressure. Effectiveness of these interventions is currently well documented in literature reviews by established researchers and clinicians (Volkow et al., 2014).

Other medications approved to treat opiate-use disorders include oral naltrexone (ReVia<sup>®</sup>, Depade<sup>®</sup>) and naltrexone sustained-release injection (Vivitrol<sup>®</sup>). Naltrexone binds strongly to the body's opiate receptors, thereby reversing the effects of opiates. This reduces opiate use because people taking these medications do not get high if they do use opiates.<sup>b</sup>

<sup>a</sup> Therapies that are not medication-assisted are also available. This fact sheet does not describe those therapies.

<sup>b</sup> Naloxone is another opiate receptor blocker that cannot be absorbed through the gastrointestinal tract. It is added to buprenorphine and taken sublingually (under the tongue). This reduces the potential for abuse because, if dissolved and injected, the naloxone blocks the effects of buprenorphine. Naloxone, a potentially life-saving drug, is also used intravenously or as a nasal spray to treat opiate overdose.

Person must stop taking opiates before being prescribed naltrexone. Those who take naltrexone as directed do not relapse, but most either refuse to take it or discontinue use. The sustained-release form of naltrexone is administered once a month, which may increase adherence to treatment. However, 6-month treatment retention rates following treatment with sustained-release naltrexone are lower than 1-year retentions in methadone maintenance (Bart, 2011). Therefore, reviews of controlled studies conclude that more evidence is needed to justify its use. However, those highly motivated to comply with treatment, such as employees under a treatment plan, will do well (Harvard Health Publications, 2005).



### ■ *Benefits of MAT*

MAT has proven effective in helping patients recover from opiate addiction. When prescribed and monitored properly, methadone and buprenorphine are safe, cost-effective, and greatly reduce the risk of overdose (Schwartz et al., 2013). Other benefits include the following:

- increased patients' retention in treatment,
- improved social functioning,
- lower risks of infectious-disease transmission through avoidance of illicitly obtained injectable drugs, and
- reduction in criminal activities, as money is no longer needed to support an addiction.

### ■ *Underutilization of MAT*

Several barriers contribute to low access to and utilization of MATs. These include the following (Volkow et al., 2014):

- A misguided belief by many that MATs merely replace one addiction with another.

- Insufficient numbers of trained prescribers, leading to improper dosing of MAT and treatment failure.
- The challenge that many treatment facility managers and staff favor an abstinence (no-medication) model (Knudsen, Abraham, & Roman, 2011). However, ORT retains patients in treatment and decreases heroin use better than treatments that do not use MAT (Mattick et al., 2009).
- Policy and regulatory barriers imposed by Medicaid programs or their managed-care organizations that reduce use of MATs. These include limits on dosages prescribed, annual or lifetime medication limits, initial authorization and reauthorization requirements, minimal counseling coverage, and "fail first" criteria requiring that other therapies be attempted first ([www.asam.org/docs/advocacy/Implications-for-Opioid-Addiction-Treatment](http://www.asam.org/docs/advocacy/Implications-for-Opioid-Addiction-Treatment)).
- While most commercial insurance plans cover buprenorphine treatment, coverage may be limited (Volkow et al., 2014).
- Limited private insurance plans that provide coverage for the long-acting injection formulation of naltrexone; most plans do not cover methadone when provided through opioid treatment programs.

The heads of the National Institute on Drug Abuse, the Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration and the medical director of the Centers for Medicare & Medicaid Services recently stated, "Expanding access to MATs is a crucial component of the effort to help patients recover [from opiate use disorders]. It is also necessary, however, to implement primary prevention policies that curb the inappropriate prescribing of opioid analgesics—the key upstream driver of the epidemic—while avoiding jeopardizing critical or even lifesaving opioid treatment when it is needed" (Volkow et al., 2014).



## ■ Websites Providing More Information:

U.S. Substance Abuse and Mental Health Services Administration: Medication-Assisted Treatment for Substance Use Disorders: <http://www.dpt.samhsa.gov/>

U.S. National Institute on Drug Abuse: Topics in Brief: Medication-Assisted Treatment for Opioid Addiction: <http://www.drugabuse.gov/publications/topics-in-brief/medication-assisted-treatment-opioid-addiction>



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