MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION

MYTHS & FACTS

Medication-assisted treatment (MAT) for opioid addiction is the use of medications, in combination with counseling and behavioral therapies, to provide a **whole-patient approach** to treatment. MAT utilizes medications, such as methadone, buprenorphine, and injectable naltrexone, to stabilize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions. **Numerous studies have shown that MAT reduces illicit drug use, disease rates, and criminal activity among opioid addicted persons.**[1] Despite overwhelming evidence of MAT's benefits, many people view it negatively. As a result, they do not use MAT and sometimes prohibit it even when clinically appropriate. Following are common myths and facts about MAT. **Relying on the facts will increase the chance that people will enter and sustain recovery.**

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MYTH
Medication-assisted treatment "substitutes one addiction for another."

FACT
When properly prescribed, addiction medications reduce drug cravings and prevent relapse without causing a "high."[2]
Methadone and buprenorphine are opioid-based and result in physical dependence, but are fundamentally different from short-acting opioids such as heroin and prescription painkillers. The latter go right to the brain and narcotize the individual, causing sedation and euphoria (a "high"). In contrast, MAT medications help patients disengage from drug seeking and related criminal behavior and become more receptive to behavioral treatments.[3] Injectable naltrexone is not opioid based and does not result in physical dependence.[4]

MYTH
Addiction medications are a "crutch" that prevents "true recovery."

FACT
Individuals stabilized on MAT can achieve "true recovery," according to leading addiction professionals and researchers. This is because such individuals do not use illicit drugs, do not experience euphoria, sedation, or other functional impairments, and do not meet diagnostic criteria for addiction, such as loss of volitional control over drug use.[5] MAT consists not only of medication but also of behavioral interventions like counseling. The medication normalizes brain chemistry so individuals can focus on counseling and participate in behavioral interventions necessary to enter and sustain recovery.[6]

MYTH
MAT should not be long term.

FACT

There is no one-size-fits-all duration for MAT. The Substance Abuse and Mental Health Services Administration ("SAMHSA") recommends a "phased approach," beginning with stabilization (withdrawal management, assessment, medication induction, and psychosocial counseling), and moving to a middle phase that emphasizes medication maintenance and deeper work in counseling. The third phase is "ongoing rehabilitation," when the patient and provider can choose to taper off medication or pursue longer term maintenance, depending on the patient's needs.[7] For some patients, MAT could be indefinite.[8] The National Institute on Drug Abuse ("NIDA") describes addiction medications as an "essential component of an ongoing treatment plan" to enable individuals to "take control of their health and their lives."[9] For methadone maintenance, NIDA states that "12 months of treatment is the minimum."[10]

MYTH
Requiring people to taper off MAT helps them get healthy faster.

FACT

Requiring people to stop taking their addiction medications is counter-productive and increases the risk of relapse.[11] Because tolerance to opioids fades rapidly, one episode of opioid misuse after detoxification can result in life-threatening or deadly overdose.[12]

MYTH

Courts are in a better position than doctors to decide appropriate drug treatment.

FACT

Deciding the appropriate treatment for a person with opioid addiction is a matter of physician discretion, taking into consideration the relevant medical standards and the characteristics of the individual patient.[13] Just as judges would not decide that a person should treat her diabetes through exercise and diet alone, and instruct her to stop taking insulin, courts are also not trained to make medical decisions with respect to medically-accepted addiction treatment.

[1] MADY CHALK ET AL., TREATMENT RESEARCH INSTITUTE, FDA APPROVED MEDICATIONS FOR THE TREATMENT OF OPIATE DEPENDENCE: LITERATURE REVIEWS ON EFFECTIVENESS AND COST-EFFECTIVENESS (Jun. 2013) at 8, 11, 24-25, available at asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final; NATIONAL INSTITUTES OF HEALTH, NIH CONSENSUS STATEMENT: EFFECTIVE MEDICAL TREATMENT OF OPIATE ADDICTION (1997), at 15-17, available at http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf; NATIONAL INSTITUTE OF DRUG ABUSE (NIDA), TOPICS IN BRIEF, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Apr. 2012), available at http://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.

[2] NIDA, supra note 1, at 1.

[3] See, e.g., NIDA, PRINCIPLES OF DRUG ADDICTION TREATMENT 11 (Martin W. Adler, Ph.D. et al., eds. 3d ed., 2012), available at http://www.drugabuse.gov/sites/default/files/podat_1.pdf.

[4] NIDA, supra note 1, at 2.

[5] See, e.g., WILLIAM L. WHITE & LISA MOJER-TORRES, RECOVERY-ORIENTED METHADONE MAINTENANCE 5 (2010); THE AMERICAN SOCIETY OF ADDICTION MEDICINE, THE ASAM CRITERIA: TREATMENT CRITERIA FOR ADDICTIVE, SUBSTANCE-RELATED, AND CO-OCCURRING CONDITIONS 5 (David Mee-Lee ed., 2013), available at williamwhitepapers.com/pr/__books/full_texts/2010Recovery_orientedMethadoneMaintenance.pdf.

[6] NIDA, DRUG FACTS: TREATMENT APPROACHES FOR DRUG ADDICTION (2009), available at http://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction.

[7] OFFICE OF NATIONAL DRUG CONTROL POLICY, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION, 3 (2012), available at http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

[8] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS: A TREATMENT IMPROVEMENT PROTOCOL TIP 43 (2008), available at http://store.samhsa.gov/shin/content/SMA12-4108/SMA12-4108.pdf.

[9] NIDA, supra note 1, at 1.

[10] NIDA, UNDERSTANDING DRUG ABUSE AND ADDICTION, (Feb. 2016) available at https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii.

[11] OFFICE OF NATIONAL DRUG CONTROL POLICY, supra note 7, at 3 (citing E. Day & J. Strang, Outpatient Versus Inpatient Opioid Detoxification: A Randomized Controlled Trial, 40 J. OF SUBSTANCE ABUSE TREATMENT, 1, 56-66 (2010)).

[12] OFFICE OF NATIONAL DRUG CONTROL POLICY, supra note 7, at 3.

[13] See, e.g., THE AMERICAN SOCIETY OF ADDICTION MEDICINE, THE ASAM CRITERIA: TREATMENT CRITERIA FOR ADDICTIVE, SUBSTANCE-RELATED, AND CO-OCCURRING CONDITIONS (David Mee-Lee, ed., 2013).

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