



# MAT for Opioid Use Disorder: Overcoming Objections

Californians struggling with substance use, including opioid use disorder (OUD), should be screened for these illnesses *wherever* they seek help; those with OUD can be treated immediately and referred for ongoing care. California is building a “no wrong door” health care system, ensuring that medications for addiction treatment are widely available in emergency departments and hospitals, primary care and mental health clinics, jails and prisons, residential treatment programs, and other care settings.

The need is urgent, since fentanyl (an extremely potent street drug) is increasingly responsible for overdose deaths for users of opioids and stimulants; fentanyl overdose deaths have more than quadrupled in California between 2014 and 2017.

Medication-assisted treatment (MAT) uses FDA-approved medicines such as buprenorphine (Suboxone), methadone, and naltrexone (Vivitrol), often supplemented by behavioral treatment and social supports. Harm-reduction services are employed to keep patients safe until they are ready to seek treatment — services such as dispensing naloxone, an opioid antidote that prevents death from overdose, and providing clean syringes to prevent HIV and hepatitis C. A medication-first approach allows patients to first be stabilized on medication, and then be brought into the right level of care to fit their needs — thereby decreasing the risk of overdose and relapse.

Despite data showing the success of MAT in treating drug addiction, objections are still common. Following are some frequent objections and evidence-based responses.

## Why treat a drug addiction with a drug?

- ▶ Buprenorphine and methadone are proven to cut overdose death rates in half while decreasing illicit drug use and HIV<sup>1</sup> and hepatitis C<sup>2</sup> transmission, and improving patient retention in treatment.<sup>3</sup>
- ▶ Injectable extended-release naltrexone is shown to reduce illicit drug use and to increase retention in treatment in three- to six-month trials.<sup>4</sup>
- ▶ Twelve-step and other abstinence-based approaches may be helpful for many substance use disorders, but they only succeed in 10% to 15% of people with opioid addiction when used alone, compared to a 50% to 80% rate for MAT.<sup>5</sup>
- ▶ Patients on MAT have lower health care costs compared to those on drug-free treatment.<sup>6</sup>

## Isn't drug-free, abstinence-based treatment better?

- ▶ Drug-free treatment is not as effective as MAT in preventing deaths. See “[Dying to Be Free](#)” about the high overdose rates in a state where only abstinence-based residential treatment was available. Relapses and deaths are common as patients struggle to maintain abstinence, since strong cravings persist for years after last use.<sup>7</sup>
- ▶ Prison system data point to the benefit of MAT in reducing deaths. The risk of opioid overdose death

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for people shortly after leaving prison is 129 times that of the general population.<sup>8</sup> After Rhode Island broadly implemented the use of MAT in its jail and prison system, overdose death rates after release dropped by 61%.<sup>9</sup>

## Can people stop taking the medications?

- ▶ The American Society of Addiction Medicine recommends maintaining buprenorphine for at least one to two years, after which voluntary slow tapers can be attempted. People early in their disease can successfully taper off. If cravings come back, it is a sign that the taper was too soon.
- ▶ People with long-term opioid use may have permanent brain chemistry changes (see the free video “[Addiction Neuroscience 101](#)” for a simple and compelling explanation)<sup>10</sup> and require long-term treatment with MAT.
- ▶ Lifelong treatment is acceptable for other chronic diseases such as diabetes, HIV, or high blood pressure. Addiction is a chronic brain disease that often requires a similar approach.

## Medications should only be used short-term.

- ▶ Using medications for a brief period only, during the detoxification period, results in high relapse rates (82% relapsing after methadone taper<sup>11</sup> and 92% relapsing after buprenorphine taper).<sup>12</sup> Death rates double after buprenorphine tapers and triple after methadone tapers.<sup>13</sup>
- ▶ Ongoing treatment with buprenorphine or methadone significantly reduces drug craving, which can last years after the initial detox period.<sup>14</sup> Cravings increase the chance of relapse and decrease people’s ability to participate in recovery and rebuild their lives.

## Buprenorphine is sold as a street drug. Isn’t it just another way to get high?

- ▶ Buprenorphine diversion can be a sign of insufficient treatment access.<sup>15</sup> Areas with high diversion tend to have low availability of legitimate treatment. Easy treatment access tends to decrease the amount of buprenorphine diverted to the illegal market.
- ▶ Most people who take illicit buprenorphine are taking it for its intended purposes (withdrawal management, detoxification, or relapse prevention) and not to get “high.” In fact, buprenorphine’s chemical qualities (as a long-acting partial agonist medication) make it much more difficult to feel euphoria from buprenorphine compared to other drugs.<sup>16</sup>
- ▶ Patients who have experienced illicit buprenorphine are more likely to stay in treatment once they start treatment.<sup>17</sup>

## Naloxone, the “rescue drug,” encourages risky drug use.

- ▶ Naloxone is an antidote, given by nasal spray or injection, that restarts breathing when someone is unconscious due to an overdose.
- ▶ Increased access to naloxone reduces mortality and has not been shown to increase drug use.<sup>18</sup>
- ▶ Communities with increased access to overdose prevention education and naloxone have seen greater reductions in opioid-related overdose deaths.<sup>19</sup>
- ▶ Naloxone distribution is cost-effective, particularly when distributed to people using heroin.<sup>20</sup>

## People with addiction need to hit rock bottom — maybe go to jail — before they will change.

- ▶ This is a dangerous misconception of the nature of opioid addiction. Long-term opioid use alters brain chemistry in a way that produces uncontrollable cravings and intense despair that can persist years after last use. Hitting rock bottom frequently means overdose death from lethal street drugs or from mixing drugs.

- ▶ Incarceration does not protect people from drug use or overdose. California’s opioid overdose rate inside prison is four times the national prison average.<sup>21</sup>
- ▶ Incarceration itself causes harm. People often lose jobs and housing, and emerge with felony records, making it much more difficult for them to get and stay in treatment after release, and more likely to resort to criminal activity to survive.

## Primary care clinicians aren’t equipped for addiction treatment.

- ▶ Buprenorphine management is more straightforward than other medications used routinely in primary care, such as insulin.
- ▶ Many resources have been developed to help primary care physicians and clinic staff learn how to treat patients with addiction:
  - ▶ Through [Project Echo](#), UC Davis offers mentoring and instruction for providers via teleconferencing.
  - ▶ California’s [Substance Use Line](#), 844.326.2626, is open 24/7 for free consultation with addiction specialists.
  - ▶ The [Providers Clinical Support System](#) offers training and mentorship, as well as 24 hours of free online addiction learning.
- ▶ Buprenorphine is available on Medi-Cal and most insurance plans without prior authorization requirements and is dispensed at pharmacies. Buprenorphine is a Schedule III controlled substance, which means it can be prescribed over the phone without a special prescription pad.
- ▶ Patients can start buprenorphine at home, which decreases the burden on the office practice.<sup>22</sup> See links for patient-centered home induction instruction sheets in [English](#) and [Spanish](#), and this [buprenorphine quick-start](#) one-page reference.

## Buprenorphine shouldn’t be offered in practices that don’t have robust treatment programs.

- ▶ Patients who can’t afford counseling or can’t afford the time off work can still benefit from MAT. Practices that do not have behavioral health services can still offer buprenorphine treatment alone.<sup>23</sup> Access to medications alone is better than no access at all.
- ▶ Some practices deploy trained medical assistants, social workers, or nurses to help with patient support and monitoring.
- ▶ A medication-first model allows people to access MAT without requiring lengthy assessments and participation in counseling. See [“Treatment for Opioid Addiction, with No Strings Attached.”](#)<sup>24</sup>

## Opioid addiction is not treatable. People just keep relapsing.

- ▶ Addiction is a chronic illness, and relapse is part of the disease. It takes smokers an average of 30 or more attempts before they stop for good.<sup>25</sup>
- ▶ MAT has about the same success rate as that for other chronic diseases requiring difficult behavioral changes, and outcomes are as good as those for diabetes and COPD.<sup>26</sup> Many people go on to reestablish productive, satisfying lives.
- ▶ The tragic impact of opioid addiction on individuals, families, and whole communities cannot be ignored when viable treatment is available and shown to have high success rates.

## Methadone clinics are more about making money than getting people off drugs.

- ▶ Like most of the US health care system, the majority of opioid treatment programs (previously known as methadone clinics) are commercial or for-profit. Many of these clinics were founded as a mission to help people with addiction.

- ▶ Methadone providers are closely regulated by the federal government and state governments and must adhere to strict clinical practices. All patients on methadone receive counseling and close supervision. Medi-Cal reimbursement rates for methadone services are set by the state and strictly controlled.
- ▶ California launched the **Hub and Spoke System** in 2017, which links methadone clinics with primary care clinics and other health care settings, enabling patients who are stable to be managed in less-intensive settings.

## Summary

MAT is effective and is not difficult for providers to manage. However, integrating addiction treatment into health care settings requires culture change. Decades of misinformation has created a culture of blame and the false belief that will power alone enables recovery.

Learning to treat opioid addiction can be an organization's first step toward building skills to help patients with alcohol use disorder (which also benefits from medications) and other addictions that require intense behavioral therapy (like methamphetamine use disorder).

Understanding the science behind addiction and treatment can help change perspectives from blame to compassion and a reduction in stigma. Addiction is a chronic disease and not a character flaw. Training in the concepts of **trauma-informed care** can help staff overcome bias and change practices. These talking points can help inform conversations to change hearts and minds.

## About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit [www.chcf.org](http://www.chcf.org).

## Endnotes

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