Barriers to Treatment

Benefits of Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) with methadone, buprenorphine, or naloxone, has been proven to help patients recover from opioid addiction.

These medications are:

* Safe
* Cost-effective
* Reduce the risk of overdose
* Increase treatment retention
* Improve social functioning
* Reduce the risks of infectious disease transmission
* Reduce criminal activity

When researchers studied heroin-overdose deaths in Baltimore between 1995 and 2009, they found an association between increasing availability of MAT (methadone and buprenorphine) and an approximately 50% decrease in the number of fatal heroin overdoses.[[1]](#footnote-1)

Underuse of Medication-Assisted Treatment

Of the 2.5 million Americans 12 years of age or older who abused or were physically dependent on opioids in 2012, fewer than 1 million received MAT.[[2]](#footnote-2) Despite their benefits, MATs have been adopted in less than half of private treatment programs. Even in programs that do offer MAT options, only about a third of patients receive them.[[3]](#footnote-3)

**Why is MAT underused?**

* Reasons for this gap between treatment need and delivery include lack of access to opioid maintenance programs,[[4]](#footnote-4) lack of training for providers (especially in rural areas),[[5]](#footnote-5) stigma, expense, and negative attitudes toward agonist maintenance in some minority communities.[[6]](#footnote-6)
* Medication-assisted treatment has saved many lives, but it is still not often accepted by the public. Patients seeking MAT for opioid dependence sometimes find that their healthcare providers may have a negative opinion of MAT despite medical evidence of its many benefits.[[7]](#footnote-7)
* Some treatment programs and insurance companies have placed many limits and regulations on who can be prescribed MAT and for what duration. These policies are often intended to ensure that MAT is the best course of treatment for their patients, but they can make it harder for patients to find the care they need.[[8]](#footnote-8) Some of these programs and insurance plans provide too low of a dose or too short of a course of MAT. Use of too low of a dose of MAT may lead to increased risk of relapse, and may shake patient’s and their medical provider’s trust in MAT unnecessarily.[[9]](#footnote-9)

Myths and Misconceptions:

Medication-Assisted Treatment for Opioid Addiction

Addicts and their families often believe many myths and inaccuracies about MAT, overshadowing the evidence in support of MAT’s benefits.[[10]](#footnote-10) Many of the negative attitudes towards MAT among patients, their doctors, and their peers may come from misunderstandings of how these treatments work. Common myths and inaccuracies about methadone treatment may prevent patients and their families from recognizing the evidence in support of methadone’s benefits.

**Myth #1:** **MAT replaces one addiction with another.**

Sometimes patients and their families or friends wonder why doctors use drugs like buprenorphine or methadone to treat opioid addiction, since these medicines are in the same family as heroin and prescription opioid pain medication. However, physician-prescribed buprenorphine and methadone are **not** just “substituting” one addiction for another.

Addiction treatment uses longer-acting and safer medications to help overcome more dangerous opioid addictions. Many studies have shown that maintenance treatment with long-acting opioids like **methadone** or **buprenorphine** helps keep patients healthier, reduces criminal activity, and helps prevent drug-related diseases like HIV/AIDs and Hepatitis.

Patients who strongly object to using maintenance opioids for any reason may choose a different type of MAT. For example, **naltrexone** is not an opioid drug, and actually works by *blocking* the effects of opioids in the brain for up to one month. For more information, see the Community Resources section of PCSSMAT.org.

**Myth #2: MAT is a bad moral choice. It is inferior to complete, unassisted abstinence.**

Some of the negative stigma of MAT comes from different ways of understanding addiction.

Addiction as a moral and spiritual problem**:** Some addicts and their communities view addiction as a moral and spiritual failing, not as a medical disease. In this view, medical treatment with methadone may seem like a “crutch,” or a weak moral choice, because the addict is continuing to use an opioid on a daily basis. Complete, unassisted abstinence is the most common treatment plan in this view of addiction. MAT’s ability to make addiction recovery easier and less painful may not be seen as a benefit, but may suggest that an addict “isn’t as serious” about quitting., MAT patients do not meet many 12-step programs’ definitions of abstinence because of their use of opioid medications, and they may be excluded from these groups. However, individuals attending 12-step groups may be criticized as having “traded one drug for another” if they reveal that they are seeking treatment with buprenorphine or methadone. This is not always the case, and many AA and NA members understand the role of MAT in recovery.

**Addiction as a medical disease:** Instead of understanding addiction as only a moral or spiritual failing, many medical professionals have begun to view opioid addiction as a medical disease. The disease of addiction can be caused by repeated exposure to a drug, coupled with genetic or environmental risk factors, leading to physical changes in the brain’s opioid receptors. In this view, addiction can be treated and managed with medication, much like other medical diseases.

**Myth #3: MAT is not effective because it does not immediately end drug dependence.**

Opioid Dependence or Addiction is not “cured” by the use of MAT. Addiction is a “chronic” (long-lasting) disease. Medical treatment for addiction can be comoared to medical treatment for other common chronic diseases like diabetes or high blood pressure. Just as diabetes is not “cured” by the use of insulin, and people with high blood pressure often continue taking medications for many years, so people with opioid addiction are not “cured” but instead well-managed by MAT.

**Misconception #4: “I’ve known a few people who could stop using opioids without help from any kind of medication. MAT is only for the weak. “**

Though opioid abuse may begin with a series of poor judgments, addiction involves real, physical changes in the brain. While some people are eventually able to quit using opioids on their own, the majority of patients go though many dangerous cycles of relapse and recovery. MAT can make the recovery process much safer, and has saved many lives by preventing death from overdose or dangerous behaviors associated with “street” drug use.

**[Link to Myths and Misconceptions Trifold]**

Negative Stigma of Methadone

Negative attitudes towards the use of methadone are common among patients, their doctors, their families, and their peers, as well as in most 12-step programs.[[11]](#footnote-11)

Methadone treatment’s negative stigma may prevent those that would benefit from methadone from seeking treatment. *“Stigma” means rejection or disgrace, which many patients feel they will suffer if they choose to seek methadone treatment.* This stigma may cause friends, family, and other addicts to look down on those who choose methadone treatment, preventing them from receiving the treatment’s full benefits. [[12]](#footnote-12) Patients often feel that they have to hide their use of methadone from others, and have trouble gaining social acceptance in their communities and among other addiction patients. **[[13]](#footnote-13)**

**Why is there a negative stigma associated with Methadone?**

Methadone is perceived by many as “substituting” one addiction for another. Methadone treatment is only provided in special addiction clinics, separated from the rest of healthcare, which may contribute to its stigma. This separation may also serve to distance methadone from the medical model of understanding addiction as an illness rather than as a moral failing.[[14]](#footnote-14)

Patients, their families, and their communities could benefit from greater acceptance of methadone treatment’s proven benefits in reducing illicit opioid use and its negative consequences. *[[15]](#footnote-15)*

Diversion and Abuse of Buprenorphine

Because Buprenorphine is safer and easier to prescribe than methadone, patients can take more than one dose home at a time. The convenience of this kind of prescription carries a risk of abuse.

**Patients may try to take more than one dose at a time.** Overdose by buprenorphine is less common than overdose with heroin or methadone because buprenorphine is only a “partial agonist” at opioid receptors in the brain, and does not cause a strong enough effect to suppress breathing to the point of death. However, buprenorphine can still be dangerous when mixed with other drugs, and life-threatening overdose and death have occurred when it is not taken as recommended by a physician. Formulations of buprenorphine like Suboxone contain built-in safety measures to prevent abuse by injection.

**Patients may sell or give their doses to other people who have not been prescribed buprenorphine and do not use it safely**. Patients interested in buprenorphine should be aware of how to use this medication safely. Overdoses can occur when street drugs or excess alcohol are taken with buprenorphine.

Buprenorphine should also be kept away from children, as life-threatening overdoses have occurred when children take this medicine.

**Reducing these risks**

**Studies have found that buprenorphine has a lower potential for abuse than other prescription opioid drugs**. Buprenorphine abuse has decreased over time since its release as a treatment for opioid dependence. Buprenorphine’s lack of euphorogenic properties makes it an unpopular drug of abuse. Individuals who are physically dependent on opioids very rarely report buprenorphine as their primary drug of abuse.[[16]](#footnote-16)

**Film vs Tablet.** Buprenorphine doses in the form of a thin film instead of a tablet have less risk of diversion.[[17]](#footnote-17)

**Patients may try to use buprenorphine to self-treat symptoms of opioid dependence, pain, or depression.** Recent studies suggest that the demand for illicit buprenorphine is not driven by users attempting to “get high,” but instead often represents attempts to self-treat symptoms of opioid dependence, pain, or depression. Clinical concerns may be best directed toward increasing access to professional buprenorphine treatment, as a lack of easy access to legal buprenorphine treatment may promote, rather than discourage, illicit buprenorphine use. Buprenorphine treatment plans may also benefit from recognizing the more complex needs of opioid-dependent patients with chronic pain and depression.[[18]](#footnote-18)

Cost and Accessibility of Injection Naltrexone

While the out-of-pocket cost for injection naltrexone is quite high ( more than $1000), many insurance plans including Medicaid now cover this medication. In addition, the manufacturer Alkermes offers a program for patients in need of discounted medication.

Finding a physician who prescribes and administers injection naltrexone can sometimes be a challenge for patients, particularly in some geographic areas. Physicians who specialize in the treatment of opioid use disorder or alcohol use disorder (addiction psychiatrists and internists with a specialty in Addiction Medicine) are more likely than the average physician to be comfortable offering a range of medication-assisted treatments for patients seeking recovery from substance use disorders.

1. Schwartz RP, Gryczynski J, O’Grady KE, et al. Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995-2009. Am J Public Health 2013;103:917- 22. [↑](#footnote-ref-1)
2. Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. [↑](#footnote-ref-2)
3. Knudsen HK, Abraham AJ, Roman PM. Adoption and implementation of medications in addiction treatment programs. J Addict Med 2011;5:21-7. [↑](#footnote-ref-3)
4. Cicero, T. J., Surrat, H., Inciardi, J. A., & Munoz, A. (2007.) Relationship between therapeutic use and abuse of opioid analgesics in rural, suburban, and urban locations in the United States. *Pharmacoepidemiol Drug Saf. Aug;16(8)*, 827-40. [↑](#footnote-ref-4)
5. Knudsen, H.K., Ducharme, L.J., & Roman, P. M. (2007.) Research network involvement and addiction treatment center staff: counselor attitudes toward buprenorphine. *Am J Addict*. *Sep-Oct;16(5),* 365-71. [↑](#footnote-ref-5)
6. Zaller, N. D., Bazazi, A. R., Velazquez, L., & Rich, J. D. (2009). Attitudes toward methadone among out-of-treatment minority injection drug users: implications for health disparities. *Int J Environ Res Public Health. Feb;6(2), 787*-97. [↑](#footnote-ref-6)
7. Knudsen HK, Abraham AJ, Roman PM. Adoption and implementation of medications in addiction treatment programs. J Addict Med 2011;5:21-7. [↑](#footnote-ref-7)
8. Clark RE, Baxter JD. Responses of state Medicaid programs to buprenorphine diversion: doing more harm than good? JAMA Intern Med 2013;173:1571-2. [↑](#footnote-ref-8)
9. Volkow, N. D., et al. (2014.) Medication-Assisted Therapies - Tackling the Opioid-Overdose Epidemic. *New England Journal of Medicine 370(22)*, 2063-2066. [↑](#footnote-ref-9)
10. Frank, D. (2011.) The trouble with morality: the effects of 12-step discourse on addicts' decision-making. *J Psychoactive Drugs 43(3)*, 245-256. [↑](#footnote-ref-10)
11. Frank, D. (2011). "The trouble with morality: the effects of 12-step discourse on addicts' decision-making." *J Psychoactive Drugs 43(3).* 245-256. [↑](#footnote-ref-11)
12. Frank, D. (2011). [↑](#footnote-ref-12)
13. Etesam, F., Assarian, F., Hosseini, H., & Ghoreishi, F. S. (2014.) Stigma and its determinants among male drug dependents receiving methadone maintenance treatment. *Arch Iran Med. Feb 17(2).* 108-14. [↑](#footnote-ref-13)
14. PCSS-MAT. [↑](#footnote-ref-14)
15. Frank, D. (2011). [↑](#footnote-ref-15)
16. Cicero, T. J., Surratt, H. L., & Inciardi, J. (2007). Use and misuse of buprenorphine in the management of opioid addiction. *J Opioid Manag. Nov-Dec 3(6)*,302-8. [↑](#footnote-ref-16)
17. PCSS-MAT [↑](#footnote-ref-17)
18. Schuman-Olivier, Z., et al. (2010). "Self-treatment: illicit buprenorphine use by opioid-dependent treatment seekers." *J Subst Abuse Treat* 39(1): 41-50. [↑](#footnote-ref-18)