Alaska Department of Health and Social Services
Division of Behavioral Health

Medication-Assisted Treatment (MAT) in SUD Residential Toolkit

If you have any questions regarding this toolkit, please contact:
heather.phelps@alaska.gov

Introduction

Division of Behavioral Health is excited to announce the release of this toolkit aimed at informing and engaging residential treatment programs about Medication-Assisted Treatment (MAT). MAT is an evidence-based treatment for clients with opioid use disorder and alcohol use disorder. As part of the state's expansion of substance use disorder (SUD) services through a Medicaid Section 1115 waiver, clients in residential treatment programs are required to have access to MAT.

This toolkit contains information about the benefits of MAT and the process and requirements for providing access to MAT in SUD residential treatment facilities. We hope these resources will be helpful to you and your organization as we partner together to assist individuals on their path to recovery.

In this toolkit, you will find the following sections:

Part 1: Overview of Medication Assisted Treatment

Part One is a collection of handouts/fact sheets. The handouts/fact sheets can be used to educate the client/patient, staff, family members, and other people involved in the client's treatment either individually or in a psychoeducational group format.

Part 2: MAT in Residential Treatment Facilities

Part Two provides an overview of state administrative procedures, the 1115 Behavioral Health/SUD waiver, and client rights as they relate to MAT. It also includes information about securing buy in and how to talk to clients about MAT.

Part 3: Establishing MAT Policies & Procedures in SUD Residential Treatment Programs

Part Three provides best practices for SUD residential treatment programs when developing the necessary policies and procedures for integrating MAT services. The end of this section lists some treatment and training resources for staff.

DBH would like to thank the following agencies for their contributions to the toolkit development: Akeela, Bartlett Regional Hospital, Fairbanks Native Association, Salvation Army Clitheroe Center, Volunteers of America

What is Medication Assisted Treatment (MAT)?

Medication Assisted Treatment (MAT) uses medications approved by the US Food and Drug Administration (FDA), in combination with counseling and behavioral health therapies, to provide a "whole-patient" approach to the treatment of substance use disorders (SUD). MAT is an evidence-based treatment for clients with opioid use disorders (OUD) (i.e. addiction to heroin, fentanyl, and prescription pain medications) and alcohol use disorders. The Surgeon General's 2016 report, Facing Addiction In America, says MAT "is a highly effective treatment option for individuals with alcohol and opioid use disorders. Studies have repeatedly demonstrated the efficacy of MAT at reducing illicit drug use and overdose deaths, improving retention in treatment, and reducing HIV transmission."[1]

Benefits of MAT

- Increasing retention in SUD treatment
- Reducing overdose
- Increasing abstinence from substance use
- Lowering risk of contracting HIV/Hep C
- Reducing medical and SUD treatment costs

MAT should be provided as part of a comprehensive treatment plan to support the functioning of individuals in all aspects of their lives. The goal of MAT is helping individuals achieve a full recovery, including the ability to live a self-directed life.[2] The type of medication chosen for treatment depends on several factors, like the client's situation and the treatment setting.[3] Each medication works differently with its own risks and benefits. When used properly, these medications do not result in a new addiction– rather they help clients manage their disorders so they can recover. Every client is unique, and the right medication is found when the person feels normal, has little to no side effects, does not feel withdrawal symptoms, and has cravings under control.

Research shows that clients on MAT for more than 1-2 years have the best rates of long-term success. Length of treatment varies depending on the client, and some clients may need to be on MAT for the remainder of their lives. The length of time a client participates in MAT depends on the needs and preferences of the client.

Methadone

A clinic-based opioid agonist that does not block other narcotics while preventing withdrawal during usage; it is a daily liquid dispensed only in regulated clinics.

Buprenorphine

An office based opiod agonist that does not block other narcotics while reducing withdrawal risk; This involves a daily dissolving tablet, check film, or six-moth implant under the skin.

Naltrexone

An office-based non-addictive antagonist that blocks the effects of other narcotics; it is a daily pill or monthly injection.

1 Kresina, T. F., Melinda, C., Lee, J., Ahadpour, M., & Robert, L. Reducing mortality of people who use opioids through medication assisted treatment for opioid dependence. Journal of HIV & Retro Virus 1.1(2015).

2 https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

3 https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf

What FDA-Approved Medications are Commonly Used for MAT?

The "medication" part of MAT refers to the use of three FDA-approved medications to treat OUD, which include buprenorphine, naltrexone, and methadone. The medications differ in terms of their effect on the brain and the challenges they address.

Medications are only part of a MAT approach. MAT medications "assist" other parts of SUD treatment. Counseling and psychosocial supports are combined with the medication to increase treatment success. Medication with psychosocial treatment is combined to help with all aspects of an opioid or alcohol use disorder.[4]

MAT for Opioid Use Disorder	MAT for Alcohol Use Disorder
Buprenorphine and Buprenorphine Products Inhibits other opioids and prevents cravings and withdrawal. Dramatically lowers overdose risk. Long-term use (of at least two years) reduces overdose risk by half; short-term use increases rate of overdose and is not considered standard of care. Offered as a monthly injection, six-month skin implant, or daily dissolving tablet or film.	**Disulfiram** Acts as a deterrent to drinking since combining it with alcohol causes physical illness. Clients cannot drink while taking this medication. It can be combined with other forms of treatment. Offered as a daily pill.
Methadone Prevents cravings and withdrawal when prescribed for pain. It does not inhibit effect of other narcotics. Offered as daily liquid and dispensed in certified and highly regulated specialty opioid treatment programs.	**Acamprosate** Reduces cravings for clients who have stopped drinking. It does not help with withdrawal symptoms. Clients can continue taking this medication during relapse. Offered as a tablet taken three times daily.
Naltrexone Blocks opioid effects while reducing cravings. Reduces risk of overdose in some trials. It is not a controlled substance and can be prescribed or administered in an office-based setting, unlike methadone. Client must be off opioids for 7-10 days before use to prevent instant withdrawals. Naltrexone is effective for highly motivated clients. Offered as a daily pill or monthly injection.	**Naltrexone** This medication blocks the euphoric effects and feelings of alcohol intoxication and reduces cravings. Naltrexone is proven to reduce drinking days and the amount of drinking per episode. Offered as a daily pill or monthly injection.

For more information about medications, please refer to the following online resources:

- **FDA:** Information about Medication-Assisted Treatment (MAT). Available at: https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat
- **SAMHSA:** Medication-Assisted Treatment (MAT). Available at: https://www.samhsa.gov/medication-assisted-treatment

4 The Pew Charitable Trusts. Medication-Assisted Treatment Improves Outcomes for Patients With Opioid Use Disorder. November 2016. Available at: https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder

What is Project HOPE

Alaska's Office of Substance Misuse and Addiction Prevention (OSMAP) Project HOPE is working with community organizations to distribute or administer Narcan in Alaska. Narcan (i.e. Naloxone) is a medication that is used to respond to opioid overdose. It temporarily blocks or reverses the effects of opioids. In most cases the effect is immediate (within 30-to-40 seconds), blocking the effects of the overdose and allowing the person to breathe again. This gives time to seek emergency medical assistance. Its use is supported by many organizations, including the US Office of National Drug Control Policy and the World Health Organization (WHO).

Organizations are eligible to apply to become distributers of Narcan through Project HOPE. These organizations may include, but are not limited to, public health centers, law enforcement agencies, fire departments, community and faith-based organizations, social service agencies, substance use treatment programs, shelters, and transitional housing agencies. Project HOPE has distributed over 12,000 opioid reversing Narcan rescue kits and provided training on use to first responders across the state. Project HOPE has also trained and approved 29 Opioid Response Programs to help ensure rescue-kit training and distribution continues at the local level.

With help from many partner agencies, Project HOPE has distributed over 25,000 drug disposal bags to communities across Alaska. This provided individuals with a means to safely dispose of opioids and other unused prescription medications. If you have questions about Project HOPE, or would like to learn more about offering rescue kits, please email: ProjectHOPE@alaska.gov.

Narcan Kit and Coverage

A prescription can be written for the patient to pick up a Narcan kit at the local pharmacy.

Narcan nasal spray is covered by Alaska Medicaid, Veterans Affairs, most Medicare Part D plans and most private insurances.

Additionally, Narcan may be purchased without a prescription at the pharmacy after a brief consultation and training with the pharmacist, although the average cost (approximately $150) may be out of reach of many clients.

What is Narcan (Naloxone)?

Naloxone is a life-saving medication that re- verses an opioid overdose. Naloxone is safe for lay people to use, as it is harmless if misused, and has no effect on an individual if opioids are not present in their system.

Naloxone blocks opioid receptor sites, reversing the toxic effects of the overdose, restarting breathing and waking people up from unconsciousness.

Naloxone can be given by intranasal spray or injection (in the muscle, under the skin, or in a vein) and should be given when someone appears to have overdosed (unconscious, with slowed breathing, or if breathing has stopped). Residential treatment programs should keep naloxone onsite in the case of emergencies. For more information on naloxone, see: https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone.

How Does MAT Help the Client?

MAT stabilizes brain chemistry by taking clients out of the cycle of cravings and withdrawal, which can last for years after their last drug use. This allows clients to engage in treatment and benefit from behavioral health interventions, like counseling. When taken properly, MAT helps clients manage their addiction so they can recover and live healthier lives.MAT also decreases the rate of deaths from overdose as follows:

- Buprenorphine and methadone cut overdose death rates in half or more, lowering opioid use, decreasing HIV and hepatitis C risk, and reducing arrest and incarceration.[5]
- Detox alone usually does not work for OUD; the longer clients stay in treatment, the greater their chance of long-term survival.[6]
- Only one out of five people with OUD can achieve two years of abstinence without medications, and those who relapse are at high risk of death. After someone has overdosed once, the chance of dying in the next year is one in ten.[7]

Long-term medication (MAT) maintenance is important to prevent relapse.

MAT reduces rate of relapse when compared to abstinence-based treatment.

MAT allows time for brain to heal, and capacity to be restored for emotional stability and decision-making capabilities.

5 American Society of Addiction Medicine, "Medication-Assisted Treatment with Buprenorphine: Assessing the Evidence." Available at bit.ly/2Vp5eaH.

6 Mathers, Bradley M et al. "Mortality among People Who Inject Drugs: A Systematic Review and Meta-Analysis." Bulletin of the World Health Organization 91.2 (2013): 102–123. Available at bit.ly/2s0NQLG; Corsi, Karen et al., "Opiate substitute treatment is associated with increased overall survival among injecting drug users." Evidence-Based Mental Health 13 (2010): 111. Available at bit.ly/2Qft5Wa; Cornish, Rosie et al. "Risk of death during and after substitution treatment in primary care: prospective observational study in UK General Practice Research Database." British Medical Journal 341 (2010): 5475. Available at bit.ly/2BSb7Eg; Kimber, Jo et al. "Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment." British Medical Journal 341 (2010): 3172. Available at bit.ly/2Ar8tFt.

7 Bart, Gavin "Maintenance Medication for Opiate Addition: The Foundation of Recovery," Journal of Addictive Diseases 31.2 (2012): 207-225.

How to Prevent Stigma Regarding MAT

People hold beliefs that form the basis of attitudes and judgements, which in turn, impacts how people react and interact with others. Sometimes the foundation of our beliefs may be faulty due to misinformation or myths.[8]

Stigma represents the negative attitudes and behaviors demonstrated toward a circumstance or person. Historically, stigmas have existed based on gender, sexuality, sexual orientation, race, culture, religion, mental health disorders, and substance use disorders.[9]

Understanding the Impact of Stigma

For generations, personal shame and public stigma has produced tremendous obstacles to addressing the problem of addiction in America. Stigma is a primary barrier to effective prevention, treatment, and recovery efforts at the individual, family, community, and societal levels. It prevents many people from getting the help that they need.[10]

Many of the negative, stigmatizing symptoms associated with addiction tend to diminish when appropriately addressed and managed in recovery. Stigma around addiction is so widespread that confidentiality laws had to be passed to protect people.

Three Components of Stigma

STEREOTYPES
Widely held, fixed, and oversimplified images or ideas of a type of person or thing.

PREJUDICE
A preconceived idea that is not based on reason or actual experience, but on a stereotype.

DISCRIMINATION
The prejudicial treatment of different categories of people or issues.

The voices of stigma come from multiple sources:

- **Self:** A person with SUD may blame themselves for their disease or feel powerless over it.
- **Recovery community:** Sometimes people in recovery create a hierarchy of what drugs are worse than others. Statements like "I only drank alcohol" or "I would never inject heroin" are indicators of stigma around certain substances.
- **Treatment providers:** Providers can be biased, too, believing only people in recovery can help people recover or that MAT is replacing one addictive drug with another.
- **The public:** Statements like "I wouldn't want a treatment center in my backyard" or "I would never hire an addict because they steal" are examples of public stigma.

Click here to view the PBS News Hour segment "Fighting the Stigma of Opioid Addiction with Stories of Recovery."

8 https://attcnetwork.org/sites/default/files/2019-04/Anti-Stigma%20Toolkit.pdf
9 https://www.camhs.ca/wp-content/uploads/2017/06/eliminating-stigma-brochure.pdf
10 https://www.hazeldenbettyford.org/recovery-advocacy/stigma-of-addiction

Ways to Diminish Addiction-Related Stigma

Learn More: If interested, there are several websites and resources within this toolkit. By learning more about MAT, everyone can better understand the benefits and share stories of hope.

Speak Out: When misinformation, prejudice, or effects of stigma are noticed, speak out and challenge inaccuracies. Educate others and guide them to reliable sources of MAT information.

Treat People with Dignity and Respect: Stigma does not survive when there is respect. By treating people with dignity and respect, we validate their experiences.

Think About the Whole Person: People are more than their health problems. Addiction does not describe what a person *is*, addiction describes what a person *has*. Avoid labels like "addict," or "drug user." Instead use people first language, for example, "a person with an opioid use disorder."

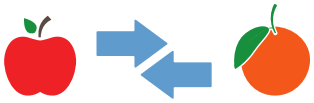
Remember that Addiction is a Brain Disease: The concept of addiction as a brain disease challenges deeply ingrained values about self-determination and personal responsibility that frame drug use as a voluntary, hedonistic act.[11]

Be Thoughtful About Language: How you describe a person's experience shapes how you view that person. Certain phrases, like "afflicted with alcoholism," contain judgments about the person with the alcohol use disorder. Using recovery terms in different contexts like "I had a relapse with my exercise program," demonstrates how words can diminish or trivialize the recovery experience.

Keep Hope: Recovery is a complex and dynamic process. Hope has the power to help people heal. By keeping hope alive, we focus on the person's uniqueness and capacity for recovery.

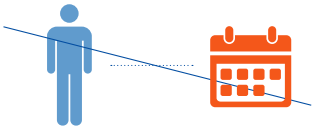
11 Neurobiologic advances from the brain disease model of addiction. The New England Journal of Medicine, 2016. By Nora Volkow, George Koob, and A. Thomas McLellan

CHALLENGING THE MYTHS ABOUT MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER (OUD)



MAT JUST TRADES ONE ADDICTION FOR ANOTHER:

MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery. (10)



MAT IS ONLY FOR THE SHORT TERM:

Research shows that patients on MAT for at least 1-2 years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MAT. (11)

MY PATIENT'S CONDITION IS NOT SEVERE ENOUGH TO REQUIRE MAT:

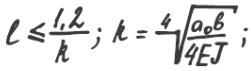
MAT utilizes a multitude of different medication options (agonists, partial agonists and antagonists) that can be tailored to fit the unique needs of the patient (2).

MAT INCREASES THE RISK FOR OVERDOSE IN PATIENTS:

MAT helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression. (14)

PROVIDING MAT WILL ONLY DISRUPT AND HINDER A PATIENT'S RECOVERY PROCESS:

MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MAT helps reduce mortality while patients begin recovery.



THERE ISN'T ANY PROOF THAT MAT IS BETTER THAN ABSTINENCE:

MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Association, The National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MAT as first line treatment. (8)

MOST INSURANCE PLANS DON'T COVER MAT:

As of May 2013, 31 state Medicaid FFS programs covered methadone maintenance treatment provided in outpatient programs (4). State Medicaid agencies vary as to whether buprenorphine is listed on the Preferred Drug List (PDL), and whether prior authorization is required (a distinction often made based on the specific buprenorphine medication type). Extended-release naltrexone is listed on the Medicaid PDL in over 60 percent of states. (5)

FOR MORE INFORMATION,
PLEASE CONTACT NICK SZUBIAK, DIRECTOR, CLINICAL EXCELLENCE IN ADDICTIONS, AT NICKS@THENATIONALCOUNCIL.ORG

1) http://www.shatterproof.org/blog/entry/medication-assisted-treatment-for-addiction 2) https://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf 3) http://www.overdosefreepa.pitt.edu/education-toolbox/medication-assisted-treatment-mat-2/#clarifying 4) http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final 5) http://store.samhsa.gov/shin/content/SMA14-4854/SMA14-4854.pdf 6) http://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines#DATA-2000 7) http://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone 8) http://www.samhsa.gov/medication-assisted-treatment/training-resources/support-organizations 9) https://www.federalregister.gov/articles/2016/03/30/2016-07128/medication-assisted-treatment-for-opioid-use-disorders 10) http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview 11) " 12) https://www.congress.gov/bill/114th-congress/senate-bill/524/text 13) http://pcss-mat.org/waiver-eligibility-training/ 14) "MAT Maintenance Treatment and Superior Outcomes" PowerPoint, Dr. Arthur Williams 15) https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-long-does-drug-addiction-treatment

Frequently Asked Questions (FAQs) about MAT from the American Association for the Treatment of Opioid Dependence (AATOD)

Does methadone treatment impair mental function?

Methadone treatment has no adverse effects on intelligence, mental capability, or employability. Methadone treated patients are comparable to non-patients in reaction time, in ability to learn, focus and make complex judgments. Methadone treated patients do well in a wide array of vocational endeavors, including professional positions, service occupations, and skilled, technical and support jobs. (Source: "Regarding Methadone Treatment and Other Pharmacotherapies" by COMPA)

How is success in methadone and other pharmacotherapy treatments defined? The primary goals are to help addicts cease heroin use and lead more stable, productive lives. But, as knowledge about heroin addiction and effective treatment practices has grown, so too have the objectives of most methadone treatment programs, which also aim to:

- Decrease criminality and reduce the numbers of substance abusers entering the criminal justice system.
- Assist patients in addressing multiple substance abuse (including crack/cocaine addiction and alcoholism).
- Assure treatment for general health matters, especially those related to drug use, such as HIV/AIDS, tuberculosis, and hepatitis.
- Promote patient employability and educational development.
- Identify and treat mental health problems and alleviate homelessness, family substance abuse, and child and family dysfunction.

(Source: Regarding Methadone Treatment and Other Pharmacotherapies by COMPA)

Why do drug-addicted persons keep using drugs?

Nearly all addicted individuals believe at the outset that they can stop using drugs on their own and most try to stop without treatment. Although some people are successful, many attempts result in failure to achieve long-term abstinence. Research has shown that long-term drug abuse results in changes in the brain that persist long after a person stops using drugs. These drug-induced changes in brain function can have many behavioral consequences, including an inability to exert control over the impulse to use drugs despite adverse consequences – the defining characteristic of addiction. (Source: NIDA, "Principles of Drug Addiction Treatment")

What is drug addiction treatment?

Drug treatment is intended to help addicted individuals stop compulsive drug seeking and use. Treatment can occur in a variety of settings, in many different forms and for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment is usually not enough. For many, treatment is a long-term process that involves multiple and regular monitoring.

There are a variety of evidence-based approaches to treating addiction. Drug treatment can include behavioral therapy (such as individual or group counseling, cognitive therapy, or contingency management), medications or their combination. The specific type of treatment or combination of treatments will vary depending on the patient's individual needs and, often, on the types of drugs they use. The severity of addiction and previous efforts to stop using drugs can also influence a treatment approach. Finally, people who are addicted to drugs often suffer from other health (including other mental health), occupational, legal, familial, and social problems that should be addressed concurrently.

The best programs provide a combination of therapies and other services to meet an individual patient's needs. Specific needs may relate to age, race, culture, sexual orientation, gender, pregnancy, other drug use, comorbid conditions (e.g., depression, HIV), parenting, housing, and employment, as well as physical and sexual abuse history. (Source: NIDA, "Principles of Drug Addiction Treatment")

How effective is drug addiction treatment?

In addition to stopping drug abuse, the goal of treatment is to return people to productive functioning in the family workplace and community. According to research that tracks individuals in treatment over extended periods, most people who get into and remain in treatment stop using drugs, decrease their criminal activity and improve their occupational, social and psychological functioning. For example, methadone treatment has been shown to increase participation in behavioral therapy and decrease both drug use and criminal behavior. However, individual treatment outcomes depend on the extent and nature of the patient's problems, the appropriateness of treatment and related services used to address those problems and the quality of interaction between the patient and his or her treatment providers. (Source: NIDA, "Principles of Drug Addiction Treatment")

Is drug addiction treatment worth its cost?

Substance abuse costs our Nation over one half-trillion dollars annually, and treatment can help reduce these costs. Drug addiction treatment has been shown to reduce associated health and social costs by far more than the cost of treatment itself. Treatment is also much less expensive than its alternatives, such as incarcerating addicted persons. For example, the average cost for one full year of methadone maintenance treatment is approximately $4,700 per patient, whereas one full year of imprisonment costs approximately $24,000 per person. (Source: NIDA, "Principles of Drug Addiction Treatment")

How long does drug addiction treatment usually last?

Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered the minimum and some opioid addicted individuals continue to benefit from methadone maintenance for many years. (Source: NIDA, "Principles of Drug Addiction Treatment")

What role can the criminal justice system play?

Research has demonstrated that treatment for drug-addicted offenders during and after incarceration can have a significant effect on future drug use, criminal behavior and social functioning. The case for integrating drug addiction treatment approaches with the criminal justice system is compelling. Combining prison- and community-based treatment for addicted offenders reduces the risk of both recidivism to drug-related criminal behavior and relapse to drug use, which, in turn, nets huge savings in societal costs. (Source: NIDA, "Principles of Drug Addiction Treatment")

Is there a difference between physical dependence and addiction?

Yes, according to the Diagnostic and Statistical Manual of Mental Disorders, the clinical criteria for "drug dependence" (or what we refer to as addiction) include compulsive drug use despite harmful consequences; inability to stop using a drug, failure to meet work, social, or family obligations; and, sometimes (depending on the drug), tolerance and withdrawal. The latter reflect physical dependence in which the body adapts to the drug,

requiring more of it to achieve a certain effect (tolerance) and eliciting drug-specific physical or mental symptoms if drug use is abruptly ceased (withdrawal). Physical dependence can happen with the chronic use of many drugs – including even appropriate, medically instructed use. Thus, physical dependence in and of itself does not constitute addiction, but often accompanies addiction. This distinction can be difficult to discern, particularly with prescribed pain medications, where the need for increasing dosages can represent tolerance or a worsening underlying problem, as opposed to the beginning of abuse or addiction. (Source: NIDA, "Principles of Drug Addiction Treatment")

How do other mental disorders coexisting with drug addiction affect drug addiction treatment?

Drug addiction is a disease of the brain that frequently occurs with other mental disorders. In fact, as many as 6 in 10 people with an illicit substance use disorder also suffer from another mental illness; and rates are similar for users of licit drugs – i.e., tobacco and alcohol. For these individuals, one condition becomes more difficult to treat successfully as an additional condition is intertwined. (Source: NIDA, "Principles of Drug Addiction Treatment")

Is the use of medications like methadone and buprenorphine simply replacing one drug addiction with another?

No – as used in maintenance treatment, buprenorphine and methadone are not heroin/opioid substitutes. They are prescribed or administered under monitored, controlled conditions and are safe and effective for treating opioid addiction when used as directed.

In contrast, methadone and buprenorphine have gradual onsets of action and produce stable levels of the drug in the brain; as a result, patients maintained on these medications do not experience a rush, while they also markedly reduce their desire to use opioids. If an individual treated with these medications tries to take an opioid such as heroin, the euphoric effects are usually dampened or suppressed. Patients undergoing maintenance treatment do not experience the physiological or behavioral abnormalities from rapid fluctuations in drug levels associated with heroin use. Maintenance treatments save lives – they help to stabilize individuals, allowing treatment of their medical, psychological, and other problems so they can contribute effectively as members of families and of society. (Source: NIDA, "Principles of Drug Addiction Treatment")

This information is online at:

http://www.aatod.org/opioid-education/frequently-asked-questions/
(last accessed on April 20, 2020).

Medication Assisted Treatment: Alaska's 1115 Behavioral Health/SUD Waiver

Alaska's 1115 Behavioral Health and Substance Use Disorder (SUD) waiver allows for new billable SUD services that strengthen and compliment the delivery of Medication Assisted Treatment (MAT). SUD care coordination facilitates a multi-disciplinary team for the client's wellness and recovery. Access to MAT has expanded significantly within the last three years in Alaska due to the increase in the number of Drug Alcohol Treatment Act (DATA) waivered prescribers. As of January 2020, nearly 400 providers have obtained a DATA waiver and are certified to prescribe buprenorphine to treat opioid use disorder (OUD) in Alaska.

State Administrative Procedures Related to MAT

Per the Alaska Behavioral Health Provider Standards and Administrative Procedures Manual, SUD residential treatment programs are required to facilitate access to or provide pharmacotherapy for the treatment of SUD. Clients should have a choice as to whether they would like to use medications to treat their SUD.

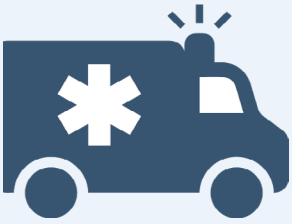
The specific administrative codes for SUD residential treatment programs and MAT services can be found at 7 AAC 135.280 and 7 AAC 70.120 For more information regarding SUD resources, please review the Behavioral Health Quality Assurance Section SUD webpage, available on the Department's website.

MAT & SUD Residential Treatment

Many clients participating in SUD residential treatment programs have been diagnosed with an opioid and/or alcohol use disorder, and therefore, could greatly benefit from MAT as part of their recovery path. Additionally, SUD residential treatment settings without MAT result in clients being at a higher risk of overdose after departure.

SUD residential treatment programs are responsible for ensuring access to MAT for clients choosing medication as treatment for SUD. If a program does not have MAT, staff should be able to arrange access to MAT services from a community provider, like an opioid treatment program (OTP), community health center, primary care provider, office-based opioid treatment program (OBOT), or other approved MAT provider.

While previous models of treatment, like abstinence models, assumed the use of opioid agonists in MAT for treating OUD were separate from formal addiction treatment; MAT is now considered a part of treatment in residential programs. Treatment efforts emphasize the inclusion of MAT as part of long-term recovery.[1]



MAT REDUCES RATE OF RELAPSE

MAT has been shownto reduce the rate of relapse when compared to abstinence-based treatment for substance use disorders.

1 Audrey Klein. What Does It Really Mean to Be Providing Medication Assisted Treatment for Opioid Addiction. 2017. Available at https://www.hazeldenbettyford.org/education/bcr/addiction-research/medication-assisted-treatment-opioid-addiction-wp-1017.

For clients participating in MAT:

- Assessment and monitoring by a medical provider
- Consistent meetings with a substance use disorder counselor
- Follow up on treatment plans based on client goals for treatment

The medical provider prescribes and monitors the medication assisted treatment for clients. Some MAT medications require special consideration when combined with other medications, including benzodiazepines (e.g. Xanax and Valium). Communication and coordination with other medical providers prescribing medications to the client is crucial to ensuring client safety.

*The rate of relapse for a client with OUD who receives treatment in a residential treatment program without MAT is 80 percent within two years – **this means only 1 out of 5 patients can transition to recovery without using medications** (and they are at high risk of death from overdose if they relapse.*

The SUD counselor plays a vital role in assisting clients who are participating in MAT. They relay important information to the medical provider, including the client's medication compliance, results from urine analysis, and level of participation in the SUD residential treatment program. The SUD counselor also observes and reports medication side effects.

The SUD counselor also may be the first person to observe, and share information to the medical provider, regarding symptoms of anxiety, depression, suicidal ideation or other mental health issues. For all these reasons, conversations between the medical provider and SUD counselor should occur regularly for clients receiving MAT in residential treatment programs. For more information about SUD counselor-prescriber communications, see TIP 63 section 4-18.

The SUD counselor also provides evidence-based psychosocial (EBP) therapies. Some examples of EBP for treatment of SUD include cognitive behavioral therapy, motivational enhancement therapy, twelve step facilitation, community reinforcement and contingency management.[2]

SUD care coordination is part of the Medicaid-covered benefit set for MAT services when provided to clients in a residential treatment program. With SUD care coordination, clients are provided access and transportation to offsite appointments, and may be provided with public transit passes. SUD care coordination also ensures clients are referred and linked appropriately to community resources as clients transition back into the community.

For more information about SUD care coordination, see Alaska Behavioral Health Provider Standards and Administrative Procedures Manual.

2 Audrey Klein. What Does It Really Mean to Be Providing Medication Assisted Treatment for Opioid Addiction. 2017. Available at https://www.hazeldenbettyford.org/education/bcr/addiction-research/medication-assisted-treatment-opioid-addiction-wp-1017.

Client Rights

- Clients have access to MAT while living is a SUD residiential treatment program, as clincially appropriate.
- Admission to a SUD residential treatment program may not be denied based on an individual having a valid prescription from a licensed health care professional for MAT.
- A client may continue MAT medication for as long as it provides a therapeutic benefit.
- Federal laws prohibit the discrimination against individuals receieving MAT.
- Clients will be allowed access to their medication for MAT while participating in a SUD residential treatment program.

Securing Buy-In

Medication-assisted Treatment Fact Sheet #1

Great Lakes (HHS Region 5)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Lack of buy-in can interfere with attempts to expand use of medication-assisted treatment (MAT) for substance use disorders (SUDs). Try the following strategies to build support for this evidence-based practice:

1 EDUCATE treatment staff, patients, family members, and the community. Offer info sessions that cover key points:

- The brain chemistry of substance use disorders
- The difference between addiction and dependence
- MAT is not "replacing one drug for another"
- The FDA-approved medications and how they work

2 SHARE THE EVIDENCE. A growing body of research shows that MAT: *

- Saves lives
- Keeps people in treatment longer
- Reduces drug-related crime

3 USE NON-STIGMATIZING LANGUAGE. Talk about MAT as a tool for managing SUDs, rather than as "harm reduction" or "not abstinence-based." *

4 ADDRESS CONCERNS ABOUT DIVERSION. Have patients sign informed consent forms; institute random pill or film counts and observed urine drug screens.*

5 SHARE SUCCESS STORIES. MAT has helped many people succeed in recovery, often after repeated failed attempts at other forms of treatment.*

6 PROVIDE STRUCTURE for treatment staff by establishing policies that define patient responsibilities for proper use of MAT.

7 AFFIRM OTHER ASPECTS OF TREATMENT. Reassure treatment staff, patients, and family members that counseling will remain a vital component of any MAT treatment plan.

8 USE A HEALTH ANALOGY. Having an SUD is similar to having a chronic condition such as diabetes or hypertension.

*See reverse for selected resources

January 2018

attcnetwork.org/greatlakes | niatx.net

Talking to Clients about MAT

The therapeutic alliance is a counselor's most powerful tool for influencing outcomes.[3] It underlies all types and modalities of therapy and helping services. A strong alliance welcomes clients into treatment and creates a sense of safety. Certain counselor skills help build and maintain a therapeutic alliance, including:

- Projecting empathy and warmth.
- Making clients feel respected and understood.
- Not allowing personal opinions, anecdotes, or feelings to influence the counseling process (unless done deliberately and with therapeutic intention).[4]

Click here to see video clip of "Patients with OUD are patients."

It is important to talk to clients about the benefits of MAT, both individually and in group settings. Staff should seek opportunities to address stigma and counteract myths with facts. When stigma presents itself, staff can use it as a teaching moment to encourage and promote understanding and well-being. The tables below describe these conversations in both the individual and group settings. For more information talking to clients about MAT, please see TIP 63 Section 4-21.

HOW TO TALK TO CLIENTS ABOUT MAT

Ask. Ask clients if they have ever considered using medication to stop their cravings for opioids or alcohol. Ask about their feelings towards using medications to assist in recovery.

Inform. Describe MAT options that may be available to the client and inform them about the benefits of MAT.

Encourage. Recommend that they consult with a medical provider to learn more. Offer referrals and linkages to external providers if MAT is not available onsite.

HOW TO TALK TO CLIENTS ABOUT MAT IN A GROUP

Address. Address any stigma that may exist in the group. Stigma may be in the form of biases around drug use and using medications as "a crutch" or "substitute."

Inform. Educate group participants about MAT, how it works and the beneifts.

Encourage. Recognize that clients all have individualized treatment, recovery, and needs.

3 SAMHSA. TIP 63: Medications for Opioid Use Disorder - Full Document, May 2020. Available at: https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

4 *Id.*

Part 3: Establishing MAT Policies & Procedures in SUD Residential Treatment Programs

This portion of the toolkit provides best practices for SUD residential treatment programs when developing the necessary policies and procedures for integrating MAT services.

Not every scenario can be addressed; therefore, residential treatment programs are encouraged to develop specific policies and procedures regarding MAT services for their clients. In addition, SUD residential treatment staff are encouraged to review the information provided in the State of Alaska's MAT Guide.

Procedures for Client Rights & Responsibilities

To make certain a common understanding exists between staff and clients, residential treatment programs provide clients with written information about their responsibilities with respect to MAT treatment. This includes having clients sign a "MAT in SUD Residential Treatment Agreement" if they choose to receive MAT as part of their treatment plan. (See MAT resources section below.)

Staff can refer to this agreement to remind clients of their responsibilities while receiving MAT. Additionally, clients receive full information about their rights. (See SAMHSA, Know your Rights: Rights for Individuals on Medication Assisted Treatment).

Procedures related to the treatment process help establish a common understanding among management, staff, and medical providers about the behaviors and outcomes expected while the client engages in MAT during their stay in a residential treatment program.

Recommendations:

- Staff have clients sign the MAT in SUD Residential Treatment Agreement.
- Non-adherence, misuse, and diversion need to be discussed with the client and the medical provider to decrease the possibility of these situations occurring and to provide informed consent to the client.
- If a client does not follow the MAT treatment plan and/or relapses, it is recommended that the medical provider and SUD residential treatment staff review and revise treatment plans accordingly, rather than discharging a client.
- Urine Drug screens are required for MAT. Drug screen results inform treatment interventions and are not used for punitive measures

Procedures for Treatment Processes Incorporating MAT

Screening and Assessment:

Residential treatment staff screen all clients for OUD.

- ✓ Residential treatment staff incorporate questions into the SUD assessment, specifically asking the client whether they are interested in starting MAT or continuing their preexisting MAT services while in SUD residential treatment.
- ✓ If the client expresses interest in starting MAT while in residential treatment, staff provide the client information about MAT services, refer client to an appropriate medical provider, and complete a release of information (ROI) form.
- ✓ If the client expresses interest in continuing preexisting MAT while in residential treatment, staff gather information on the assessment about MAT services, complete an ROI to obtain the client's information from the medical provider, and ensure the next appointment for MAT is scheduled.

Treatment

- ✓ Staff include the medical provider as much as appropriate/possible for care coordination.
- ✓ Appointments with the medical provider are based on treatment progress, recovery status, and other factors.
- ✓ Residential treatment staff make MAT as accessible as possible to all clients, including providing transportation to appointments, providing passes, and scheduling.
- ✓ Progress notes and treatment plans clearly document MAT participation.
- ✓ Anxiety, depression, suicidal ideation, and other mental health issues receive regular monitoring and intervention if necessary.
- ✓ Staff monitor clients participating in MAT for withdrawal signs and symptoms.
- ✓ To increase the success of MAT, family participation is recommended.
- ✓ All clients, regardless of whether they are participating in MAT or not, will attend a psychoeducational group about MAT.

SUD Care Coordination

SUD care coordination services must be provided, at a minimum of, once per week to a recipient who is receiving MAT. These services include following:

- ✓ Providing a comprehensive assessment and periodic reassessment to determine the individual needs for any medical, behavioral health, educational, social, or other services
- ✓ Coordinating the integrated delivery of behavioral health and medical services

- ✓ Assisting the client with level-of-care transitions
- ✓ Assisting the client to develop the skills necessary for the self-management of treatment needs and maintenance of long-term social supports
- ✓ Providing monitoring and follow up activities

For more information about SUD care coordination, please see the Alaska Behavioral Health Provider Standards Manual.

Procedures for Client Discharge & Termination

Residential treatment programs should have clear guidelines regarding their voluntary and involuntary discharge procedures for clients, including any procedures for appealing decisions for discharge. This includes providing clients with information about how to continue care, including MAT, after discharge from a residential treatment program.

Discharge Planning:

- ✓ MAT-prescribing medical provider is included in discharge planning, if appropriate.
- ✓ If the discharge is planned, the discharge plan includes the continuation of MAT.
- ✓ If the discharge is unplanned, staff strive to ensure the client continues MAT.
- ✓ Regardless of discharge status, the client will receive a Narcan kit.
- ✓ Regardless of discharge status, the client will receive their prescribed MAT medications.

Procedures for MAT Medications

While residential treatment programs have existing policies for medications, most of these policies typically include a few statements regarding controlled substances. MAT-specific policies include procedures for MAT medication storage, oversight and documentation, of medication self-administration, disposal of unused or expired MAT medications, requirements for staff training, and necessary qualifications related to supervising MAT-medication administration.

Additionally, policies must allow clients to access their MAT medications while staying at a residential treatment program. Residential treatment staff do not endorse one medication over another; instead, staff provide education about each medication and make appropriate referrals to the medical provider for guidance.

Induction/Initiation of MAT Medications

- ✓ All clients prescribed MAT will be seen face-to-face (or via telehealth) by the medical provider prior to the initiation of MAT medications.
- ✓ Informed consent form is required prior to administration of any injectable or subdermal MAT medications. The medical provider is responsible for obtaining this informed consent from the client.
- ✓ Induction for buprenorphine may occur at an OBOT or at the residential treatment program. Staff considerations include transportation to the OBOT, staff monitoring of the induction process if it occurs at the residential treatment program and identification of what to do if the induction process is not going as planned.
- ✓ If initiation for methadone occurs at an OTP, policies and procedures clearly state whether residential staff remain present during the methadone initiation process.
- ✓ Vivitrol involves lab work and a naltrexone challenge prior to the administration of the injection. The residential treatment program ensures it has the necessary staff capacity to provide clients with transportation to the medical provider for multiple appointments.
- ✓ A memorandum of understanding (MOU) between the medical provider and residential treatment program is recommended. (See MAT resources section below.)

Receipt of MAT Medications:

- ✓ Because buprenorphine and methadone are controlled substances, residential treatment programs ensure procedures provide for proper inventory of these medications, whether they are brought in by a client, pharmacy, family, or by mail. Additional security and specialized storage for MAT medications are required.
- ✓ If the MAT medication is brought to the residential treatment program by a client upon admission, the medication must be verified by a medical provider. If the medication is not verified by a medical provider, then the client will be notified and the medication will be stored, or properly disposed of, according to the policies and procedures of the residential treatment program.
- ✓ All controlled substances must be kept in a separately locked bin or safe within a locked cabinet behind a secured door of the medication room. MAT medications are stored according to the manufacturer's prescription label, which includes appropriate storage instructions like the required temperature.
- ✓ If the client is prescribed take-home doses of methadone by an OTP, the methadone will be transported to the residential treatment program in a locked box and then stored in a locked box, within a locked cabinet onsite.

Administration of MAT Medications

- ✓ MAT medication may be oral, injectable, or subdermal.
- ✓ MAT medications may be self-administered or staff-administered at the residential treatment program, OBOT, OTP or another approved medical provider location. Residential treatment programs establish clearly defined protocols that address how and where MAT medications are administered.
- ✓ Staffing considerations for offsite medication administration include transportation to the OBOT, OTP or another approved medical provider.
- ✓ Staffing considerations for onsite medication administration include allotting time for the administration of MAT medication. For example, some forms of buprenorphine take between three-to-ten minutes to dissolve.
- ✓ MAT medications are documented in a medication self-administration log or medication dispensing log.
- ✓ Residential treatment staff conduct routine reviews of medication counts, storage areas and documentation logs. Any discrepancies must be documented, addressed, and reconciled.
- ✓ Medical providers and residential treatment staff ensure clear communication regarding changes of dosage amounts and/or timing of administration.

Non-Adherence to MAT Medication

- ✓ Nonadherence to MAT medications will be documented and communicated to the medical provider. Nonadherence may include client refusal of medication, a missed dose of medication, taking the wrong dosage of medication, taking the medication at a different time than prescribed, or any other deviation from how the MAT medication was prescribed.

Disposal of MAT Medications

- ✓ MAT medications in need of destruction are stored in designated bins away from the rest of the client medications.
- ✓ MAT medications disposed of, or destroyed, are documented in a destroyed medication log.
- ✓ Controlled substances are properly disposed of, or destroyed, in accordance with Drug Enforcement Administration (DEA) guidelines.

Procedures for Diversion Control

Drug diversion is a medical and legal issue, where legally prescribed controlled substances have been transferred from the person for whom it was prescribed to another person for illicit use. Decades of research have shown that the benefits of MAT greatly outweigh the risks associated with diversion.[1] Diversion of buprenorphine is uncommon; when it does occur, it is primarily for managing withdrawal symptoms.[2] Residential treatment staff are aware of the procedures in place to facilitate diversion detection with the goal of preventing client harm.

Residential treatment programs have practices in place to achieve the following with respect to diversion:

- ✓ Procedures to deter controlled substance diversion.
- ✓ Clearly defined and solution-focused interventions for substantiated diversions.
- ✓ Training of staff for signs of possible diversion.

Procedures for Staff Training

With increased awareness of OUD and increased public investments in combatting the OUD epidemic, the field for SUD treatment, including MAT, is rapidly evolving. New approaches, treatment models, and medications are emerging. Residential treatment staff need access to the latest information and strategies to treat clients with OUD.[3] Training for staff is recommended to increase staff's ability to support clients who choose MAT as a pathway to recovery and work with MAT providers in their communities.

Below are topics to consider addressing in a MAT training for staff:

- ✓ MAT medication receipt, storage, administration, and disposal
- ✓ Addressing stigma
- ✓ Observing and reporting side effects and mental health issues to medical providers
- ✓ Nonadherence and diversion
- ✓ Treatment engagement
- ✓ Role of urine analysis and testing to inform treatment decisions
- ✓ Duration of MAT
- ✓ Family inclusion
- ✓ SUD care coordination

1 https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf
2 https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction
3 https://integrationacademy.ahrq.gov/products/mat-playbook/strategies-support-staff

MAT Resources

Below are a few MAT-related resources and examples or templates of various policies and agreements that residential treatment programs may want to consider when developing their own agreements and procedures for MAT services.

MAT Client Treatment Agreements:

- ✓ Agreement Example from ASAM
- ✓ Sample from Alaska MAT Guide

Diversion:

- ✓ University of Wisconsin – Madison Addiction Treatment Transfer Center (ATTC) MAT Diversion; Fact Sheet for Reducing Risk of Misuse of Diversion
- ✓ ASAM Sample Diversion Policy
- ✓ PCSS Guidance on Adherence, Diversion and Misuse of Sublingual Buprenorphine

Staff Training:

- ✓ Comprehensive Medication Assisted Treatment Webinar: This 1.5 hour presentation includes a discussion of different types of medication-assisted treatments for alcohol, nicotine, and opioids with an emphasis on the role of the doctor, medical staff, and substance use disorder counselor. Included is information about each of the medications and what they are designed to do. The conversation progresses into how the doctor identifies clients that would benefit from MAT, as well as the information that the counselor needs to have available to engage the client, help to develop compliance with the regimen, and how to prepare the client for eventual withdrawal from the long-term maintenance medications, or for ongoing maintenance. This part of the discussion includes the pros and cons of the client's decision, and how to implement that decision.
- ✓ MAT for Opioid Use Disorders Video Interview Series: Six videos that range from about three to ten minutes and cover the following topics: An Overview of MAT for OUD, Naltrexone, Pregnancy and MAT, Methadone, Duration of MAT, and Buprenorphine.
- ✓ TIP 63: Medications for Opioid Use Disorder: This Treatment Improvement Protocol (TIP) reviews the use of the three Food and Drug Administration (FDA)-approved medications used to treat OUD—methadone, naltrexone, and buprenorphine—and the other strategies and services needed to support recovery for people with OUD.