



Medication Assisted Treatment for Opioid Addiction:

Another Trip Down the "Rabbit Hole"?

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Medication Assisted Treatment (MAT) refers to the treatment of Opioid Use Disorder with buprenorphine, methadone, or naltrexone. MAT has been touted by professional organizations and addiction specialists as the treatment of choice for opioid use disorder. Promotion by the pharmaceutical industry has enabled MAT to quickly become society's silver bullet for the opioid epidemic. Is MAT an effective, evidence-based treatment? Is it a knee-jerk response to political pressure to eliminate the current opioid overdose epidemic? Or is it another push by the pharmaceutical industry to sell medications by a sales force with very loose tongues and very little evidence? The following is a contrasting view of MAT and addiction treatment.

The once used "harm reduction" model was the basis for legislation that permitted the use of Opioid Treatment Programs (OTP) during the heroin epidemic of the 1960s. OTPs, pejoratively known as methadone clinics, focused their treatment of opioid addiction solely on the substitution of heroin, an illegal opioid, with methadone, a prescribed opioid, and called it methadone maintenance. OTPs were not widely accepted by mainstream America and probably added unnecessary stigma to the disease of addiction. Receiving care at an OTP was never equated with long-term recovery. OTPs were not successful in their fundamental function of improving health and social rehabilitation.¹

MAT is an evolutionary step from the OTP harm reduction model. MAT, which includes the opioid agonist methadone, the partial opioid agonist buprenorphine, sometimes the opioid antagonist naltrexone, and psycho-social therapies, is now widely accepted as the treatment of choice for Opioid Use Disorder. Even without long-term studies as evidence, MAT programs are now being touted as an effective tool to stabilize addiction, reduce crime, and improve public health. Is this another trip down the "rabbit hole"?

Déjà Vu All Over Again

If this sounds like déjà vu, it is. In the 1990s we saw a push by the pharmaceutical industry and the pain experts they financed to market high dose, highly addictive pain medications for the treatment of non-cancer chronic pain to primary care doctors. Despite a dearth of evidence, professional associations, the Veterans Administration, and regulatory bodies all jumped on the bandwagon. Pain clinics opened in strip malls, staffed by poorly trained non-pain specialists that were attracted to the high pay. Physicians were lured out of retirement by an email promising easy work and lucrative salaries. Most of these physicians were not trained in Pain Management. They were recruited for one reason: their ability to write a prescription for a Schedule II medication. We have all witnessed the avalanche of human disaster that resulted from the lack of evidence-based medicine. We are still living in the catastrophic wake. I believe MAT is the second wave.

Professional associations, health insurance companies, and federal pressure masked as funding have all endorsed or financed MAT for treating opioid use disorder. The federal legislation that provided financial resources came from the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, which provided or mandated money for needed addiction treatment. The federal legislation that enabled office-based opioid treatment using MAT came from DATA-2000, a federal law that allows "qualified" physicians to dispense or prescribe specifically approved Schedule III (Buprenorphine), IV, and V narcotic medications for Opioid Use Disorder. The training requirement for DATA-2000 is successful completion of a paltry eight-hour CME course. An eight-hour CME course is the minimal education requirement that permits a licensed physician with no formal training in Psychiatry, Addiction Medicine, Internal Medicine or Family Medicine to

prescribe buprenorphine for Opioid Use Disorder (OUD) in his or her office. This "perfect storm" of insurance mandates, federal money, and waivers enabled the pharmaceutical industry to once again push their products to poorly trained physicians. This also provided an incentive for entrepreneurial physicians to set up "Bup Clinics" providing MAT services as a cash-only business.

MAT vs. Abstinence-Based Recovery

Office-based MAT is the perfect economy. Patients are fearful of withdrawal symptoms, so they are craving to return for their every two-week or every month appointment, dependent on the length of their prescriptions. Patients are willing to pay cash for these services even if they have insurance, as most Bup clinics accept cash as the only payment. Even practices that accept insurances, including TennCare, for medical services will only accept cash for their MAT patients. Contrast this economy of services with abstinence-based recovery. There is little reason to see abstinence-based recovering patients every two weeks or even monthly once they are stable. Most abstinence-based recovering patients have little need to see a physician; rather they are much more likely to use their out-of-pocket cash for a therapist or attend 12-step meetings where there is no required payment. Office-based MAT clinics are a cash cow, compared to an abstinence-based medical clinic.

My biggest concern with MAT is the use of buprenorphine or methadone as a treatment for addiction. The etiology of addiction is multifactorial. The three main factors are genetics, adverse childhood experiences, and exposure to addictive substances or processes. Patients who develop active addiction are isolated and are dependent on a substance or process for relief of their internal turmoil. Patients with active addiction are spiritually bankrupt. That is, they don't trust and lack

meaningful connections with other people, usually a result of childhood trauma. The basic treatment for addiction is based on group therapy. Group therapy allows the patient to develop connections with others. Those connections can even allow trust to develop. Twelve-step meetings are all about connections. When a patient with a substance use disorder reaches for a phone instead of a drug for help, he or she is in recovery. Buprenorphine and methadone obstructs that level of recovery and healing because the patient remains dependent on a drug for comfort.

We already have an effective treatment for addiction that has been shown by evidence-based medicine to have the highest sobriety rates. Professional health programs that physicians, airline pilots, lawyers, and other professionals use are very successful. These programs have documented long-term sobriety rates of about 85 percent at five years. These programs mandate long-term residential treatment which is expensive and generally not covered by insurance. They utilize compliance monitoring for two to five years and sometimes longer, with requirements that include 12-step meeting attendance, weekly professionals' meetings, toxicology screening, and other modalities as needed. The reason professional health programs are so successful is because they ensure that the professional gets connected and engaged in recovery. Abstinence happens in the first week of treatment. Recovery, which encompasses the process of making connections with other people, is the key for maintaining abstinence. Recovery is a spiritual process that happens when one person connects at a meaningful level with another person. Buprenorphine and other abusable mood-altering drugs eclipse that process, making recovery that much more difficult to obtain.

Addiction, like pain, is a complex disease. Addiction causes more mortality and morbidity than any other preventable disease in the United States. Addiction, probably more so than other chronic diseases, has bio-psycho-social components that respond to chronic disease management. All three of these components need be addressed for a good outcome. An online eight-hour CME course cannot begin to touch the knowledge base needed for even one of the components of addiction, let alone the triune. Yet most MAT clinics use the ability to prescribe buprenorphine as the only employment standard for their physicians.

MAT Not a Silver Bullet

Although it may seem that I am against MAT, I'm not. MAT is a harm reduction model. It should not be confused with abstinence-based recovery. MAT's role is to keep patients alive who have OUD and are at risk for overdose until they can or are willing to become abstinent. MAT has its place but is not a silver bullet when it comes to treating OUD. Once a patient is on MAT with buprenorphine it becomes exceedingly difficult to taper that patient off — we learned this from the methadone maintenance era. How can a physician with limited training in addiction medicine develop the skill set needed for this?

The fallacious comparison of buprenorphine to insulin is often made when MAT is compared with or challenged by abstinence-based recovery. The question that is always asked is, "A doctor wouldn't withhold insulin from a patient with diabetes, so why would we withhold buprenorphine from a patient with OUD?" Buprenorphine is an opioid agonist and has an effect on the opioid receptors similar to morphine and heroin, only with less respiratory depression.

It restores the hypodopaminergic state that is found with active addiction in the craving-reward part of the brain, the epicenter of which is the Nucleus Accumbens. A patient with diabetes has an insulin deficiency or insulin resistance. They require exogenous insulin to process glucose and to survive. A patient with OUD does not need an exogenous opioid to survive. Too much insulin or an opioid can cause death, albeit by very different mechanisms. Not enough insulin can cause death, whereas not enough or no opioid will not cause death. Abstinence-based recovery will treat the emotions that go with addiction. Buprenorphine, like all other opioids, only numbs the emotions of the limbic system, not allowing for the healing recovery process.

I may have more reverence for MAT if there were no other strategies to treat OUD without an opioid. We don't treat alcohol use disorder with maintenance alcohol or with benzodiazepine replacement therapy, even though alcohol and benzodiazepines have very similar actions at the GABA receptor. We don't treat methamphetamine use disorder with amphetamines or other stimulants. MAT is a harm reduction model now pushed by pharmaceutical companies with very little to no evidence to support its efficacy at promoting long-term recovery. MAT is a harm reduction model that I believe Addiction Medicine is following right down the rabbit hole. ■

¹ Dole VP, Nyswander ME. Methadone Maintenance Treatment: A Ten-Year Perspective. JAMA. 1976;235(19):2117-2119.



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