Myths and Facts About Medication-Assisted Treatment

Catching Up With COSSAP, December 2021

Medication-assisted treatment (MAT) has been shown to be a safe and effective method for treating opioid use disorders (OUDs), whether involving heroin, fentanyl, or pain relievers. This fact sheet debunks myths that continue to circulate about this treatment option and specifically addresses falsehoods about MAT in jails.

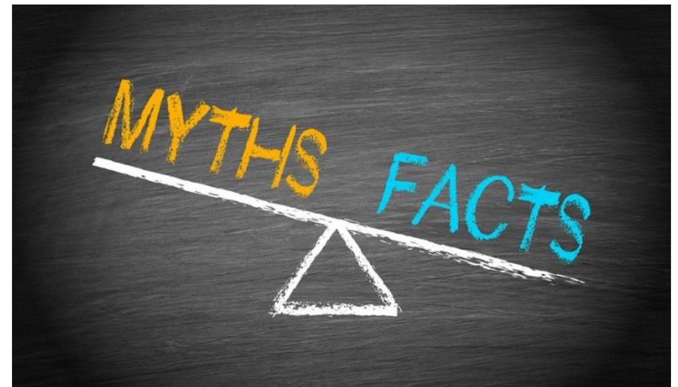
MAT is a holistic, or whole-person, approach to opioid and other substance use disorders that includes therapy and lifestyle changes in addition to medication. The U.S. Food and Drug Administration (FDA) has approved three medications for MAT:[1] methadone, buprenorphine, and naltrexone.

	Methadone	Buprenorphine	Naltrexone
What it does	Relieves withdrawal symptoms and prevents cravings without inducing euphoria	Relieves withdrawal symptoms and decreases cravings without inducing euphoria	Blocks euphoria and pain-killing effects of opioids[2]
Type of drug	Full opioid agonist	Partial opioid agonist	Opioid antagonist
Administration	Liquid, tablet, powder, diskette	Sublingual (under tongue), tablet, implant	Extended-release injection, tablet
Brand name	—	Suboxone	Vivitrol

MAT Myths and Facts

Myth: MAT is just swapping addictions.

Reality: In fact, MAT helps heal damaged circuits in parts of the brain. Proper medication is part of an effective approach that includes therapy and lifestyle changes. Although some people can get high using methadone or buprenorphine, that's not true for someone who has an OUD and uses opioids regularly.[3] For such individuals, the



medications work differently, tamping down cravings and withdrawal symptoms. While it is possible to overdose on methadone, that generally only happens when a person uses methadone that was prescribed for someone else.[4] In fact, research shows that methadone and buprenorphine are associated with reductions in opioid-related deaths.[5]

Myth: Everyone who uses MAT gets the same dosage and reacts the same way.

Reality: MAT is tailored to the individual receiving it. Prescriptions are for one of the three FDA-approved medications for MAT at a dosage that is adjusted for the person's size and body type, as well as their history of opioid use.[6] As with any medication, people may respond to the same prescription in different ways, so it's not uncommon to make medication changes or dosage adjustments.

Myth: If you start MAT, you must continue it for the rest of your life.

Reality: MAT is different for everyone, and that includes the length of time it is needed. Some people choose to taper off medication over time while others will continue on their recovery path and stay on medication for several years. MAT's effectiveness depends, in part, on how long an individual has been using opioids and how much their

brain has been affected by them.[7] Some people stay on MAT indefinitely.

Myth: It's better just to go cold turkey.

Reality: Addiction is a disease that affects your brain. If an individual stops or is forced to stop using a substance abruptly, including opioids, withdrawal symptoms can be intense and potentially harmful—even deadly. Symptoms can include vomiting, diarrhea, sleep problems, muscle aches, a runny nose, sweating, anxiety, agitation, and intense cravings for opioids, alcohol, or other substances. Withdrawal may lead to dehydration or other health complications that can be fatal. In addition, people with OUDs who discontinue use without the support of MAT are far more likely to relapse than people who receive MAT.[8]

Myth: Insurance doesn't pay for MAT, and it is expensive.

Reality: The Affordable Care Act mandates that insurance companies pay for treatment for OUD.[9] The World Health Organization added both methadone and buprenorphine to its *Model List of Essential Medicines*, "the medicines that need to be available in a functioning health system at all times, in appropriate dosage forms, of assured quality, and at prices individuals and the community can afford."[10] Some states have regulations that may affect which medications are covered.[11]

Myth: Individuals must go to a clinic every day to get the treatment.

Reality: Certified opioid treatment programs (OTPs) and outside providers administer medications onsite. Methadone is commonly administered this way, although people who have made progress in their treatment and seem to be at low risk for diversion or sharing medication illegally may be allowed to bring it home.[12] The FDA has approved prescription buprenorphine. This means that with a prescription from their doctor—individuals can take it at home. More recently, the FDA approved a six-month implant and a once-a-month injection of buprenorphine for people who are already regularly taking it. All medications taken at home must be stored safely, out of the reach of children and other vulnerable populations.

Myth: Women who are pregnant or breastfeeding should not be prescribed MAT.

Reality: Stopping opioids suddenly during pregnancy may cause a miscarriage or early labor.[13] Therefore, both the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American College of Obstetricians and Gynecologists recommend that pregnant women receive MAT.[14] Methadone has long been recognized as the gold standard of care for pregnant women with OUDs.[15] Infants born to women who have received MAT are likely to experience neonatal abstinence syndrome and will need treatment. Women who are receiving MAT and have recently given birth may be able to breastfeed, depending on their health and the health of the newborn.[16]

Myth: If you receive medication for an OUD, you don't need any other treatment.

Reality: SAMHSA defines MAT as "the use of medications, in combination with counseling and behavioral therapies, to provide a 'whole-patient' approach to the treatment of substance use disorders."[17] Federal law requires that anyone being treated in an OTP must also receive counseling in the form of behavioral therapy with a trained professional. This approach is supported by studies showing OUD treatments are most effective when they include counseling in combination with medication.[18] Counseling can help teach new behaviors and strategies for trigger avoidance and stress relief. Both the Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act address coverage of mental health and substance use disorder treatment, requiring health plans to cover those at the same level of benefits they do physical health issues.[19]

Myth: There's no proof that MAT works.

Reality: Extensive scientific research has been conducted on the effectiveness of MAT for OUD. Methadone, for example, has been used as a treatment for opioid dependence since the 1950s and has been well researched over that time.[20]

MAT and Jails

Myth: You can't get MAT in jail.

Reality: Many jails around the United States have MAT programs for both pre- and post-trial populations. The programs may be run by the jail or by an outside OTP. MAT for pretrial populations, while less common, is often offered to individuals who are most likely to return to their

communities sooner rather than later and after they have gone through medically managed withdrawal. Some facilities offer MAT-specific programming and have a case manager on staff who provides individualized assistance and in-person support for up to one year after release. Individuals eligible for Medicaid who were enrolled in a MAT program while in jail are entitled to continued coverage under Medicaid upon their release. For more information, see the *Implementing MAT in Jails* series below:

- *Implementing MAT in Jails*—Focus on Methadone
- *Implementing MAT in Jails*—Focus on Buprenorphine
- *Implementing MAT in Jails*—Focus on Naltrexone

Myth: Offering MAT increases the accessibility of drugs for people who are incarcerated.

Reality: Jails with MAT programs have actually reported a decrease in the demand for illicit drugs and a reduction in disciplinary problems.[21] Nonetheless, diversion remains a concern, and strict dispensing protocols must be followed to mitigate risk. For example, monthly injectable forms of medication essentially eliminate the risk of diversion, and even medication strips—which dissolve faster than pills—render diversion less likely. Best practices for medication administration include medication lines and dispersal windows, dual mouth-checks by both correctional staff and medical staff, and drug testing to confirm individuals adhere to prescribed doses.[22] For more risk-mitigation strategies and techniques, please visit:

- *Medication-Assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion* by the Bureau of Justice Assistance (BJA) and SAMHSA.

- Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings by SAMHSA.

- *Jail-based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* by the National Sheriffs' Association and the National Commission on Correctional Health Care.

If your jail needs training or technical assistance regarding MAT or other matters related to substance use disorders, complete a training and technical assistance request form on BJA's COSSAP Resource Center at https://www.cossapresources.org/Program/TTA.

This project was supported by Grant No. 2019-ARBX-K061 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Endnotes

1. MAT is not the same as medication for opioid use disorder (MOUD), a standalone form of treatment that relies exclusively on medication.

2. Intramuscular extended-release naltrexone is approved by the FDA as a MAT option for alcohol use disorder, as well as for OUD.

3. National Institute on Drug Abuse, 2018, "What Are Misconceptions About Maintenance Treatment?" *Medications to Treat Opioid Use Disorder Research Report*, Bethesda, MD: National Institutes of Health, retrieved September 16, 2021, from https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/what-are-misconceptions-about-maintenance-treatment.

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5. National Institutes of Health, 2018, "Methadone and Buprenorphine Reduce Risk of Death After Opioid Overdose," news release, retrieved September 16, 2021, from https://www.nih.gov/news-events/news-releases/methadone-buprenorphine-reduce-risk-death-after-opioid-overdose.

6. Substance Abuse and Mental Health Services Administration, 2021, *Medication-Assisted Treatment (MAT)*, Rockville, MD: U.S. Department of Health and Human Services, retrieved September 16, 2021, from https://www.samhsa.gov/medication-assisted-treatment.

7. Pew Charitable Trusts, 2020, *Medications for Opioid Use Disorder Improve Patient Outcomes*, fact sheet, retrieved September 16, 2021, from https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes.

8. Azhar et al., "Medications for Opioid Use Disorder: A Guide for Physicians."

9. Abraham, Amanda J., Christina M. Andrews, Colleen M. Grogan, Thomas D'Aunno, Keith N. Humphreys, Harold A. Pollack, and Peter D. Friedmann, 2017, "The Affordable Care Act Transformation of Substance Use Disorder Treatment," *American Journal of Public Health* 107(1): 31–32, retrieved October 14, 2021, from https://doi.org/10.2105/AJPH.2016.303558.

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12. American Society of Addiction Medicine, 2015, *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, retrieved September 28, 2021, from https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24.

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14. Ibid.

15. National Institute on Drug Abuse, 2017, *Treating Opioid Use Disorder During Pregnancy*, policy brief, retrieved August 31, 2021, from https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy.

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17. Substance Abuse and Mental Health Services Administration, *Medication-Assisted Treatment (MAT)*.

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