



**Getting Started with  
Medication-assisted Treatment**  
*With lessons from Advancing Recovery*



## Getting Started with Medication-assisted Treatment

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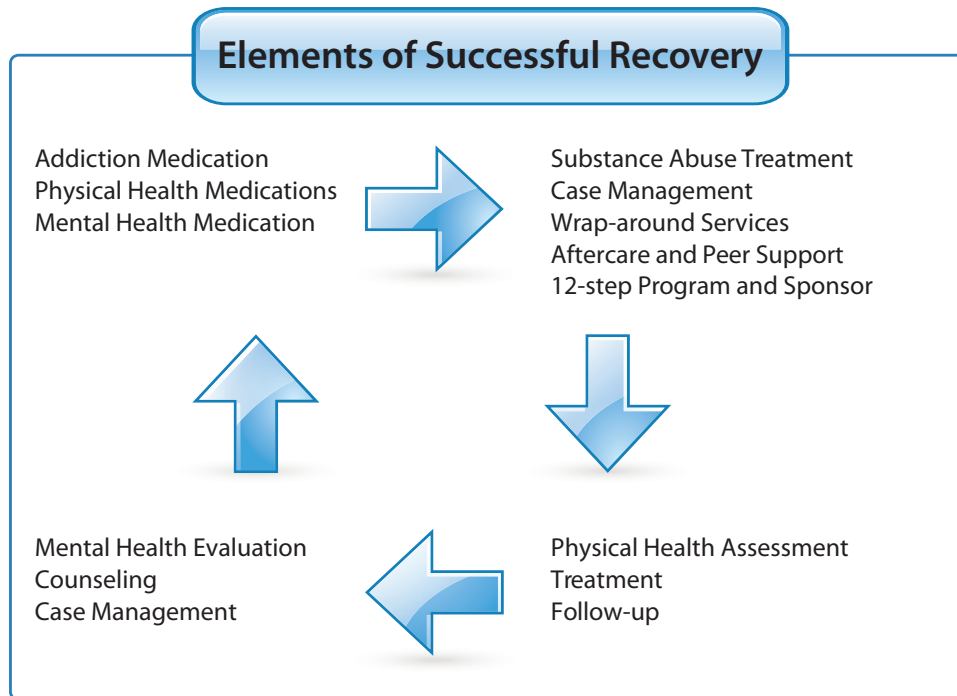
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## Introduction

Medication-assisted treatment (MAT) is the use of medications, combined with counseling, to treat substance use disorders. Research has proven the effectiveness of MAT and addiction treatment experts endorse it, but a variety of barriers have prevented the widespread use of MAT. These include a lack of financing for medication, insufficient organizational infrastructure to deliver medication, state and county funding and regulatory obstacles, physician training and certification, staff and client resistance, and community attitudes.

Advancing Recovery: State/Provider Partnerships for Quality Addiction Care (AR) was a national initiative funded by the Robert Wood Johnson Foundation. The five-year (2005–2010) project was co-directed by the Network for the Improvement of Addiction Treatment (NIATx) at the University of Wisconsin–Madison and the Treatment Research Institute (TRI) in Philadelphia.

The goal of the grant was to promote the use of evidence-based practices such as MAT through innovative partnerships between state agencies and treatment organizations. This toolkit shares lessons that emerged from the efforts of several of the grantees to establish MAT programs in their organizations.



Source: Doug Denton, Executive Director, Homeward Bound, Dallas Texas

The National Institute on Drug Abuse (NIDA) endorses medication in treating substance use disorders, and especially combining it with counseling and other behavioral therapies. Medications that have emerged in recent decades have transformed lives. Ongoing research efforts are testing additional medications that show promise for treating alcohol and cocaine addiction.

The National Quality Forum has developed consensus standards for addressing substance use illnesses. Four of the eleven standards focus on the use of medications. Specifically, they state that everyone receiving detoxification or treatment for opiate, alcohol, or nicotine dependency should be offered medications.

“Bridging the Gap Between Practice and Research: Forging Partnerships with Community-Based Drug and Alcohol Treatment,” a report issued by the Institute of Medicine in 1998, discusses the gap between what scientific research has found to be effective treatment for substance use disorders and the type of care delivered in substance-abuse treatment settings. Since then, NIDA and SAMHSA have been working to bridge the gap identified in the report.

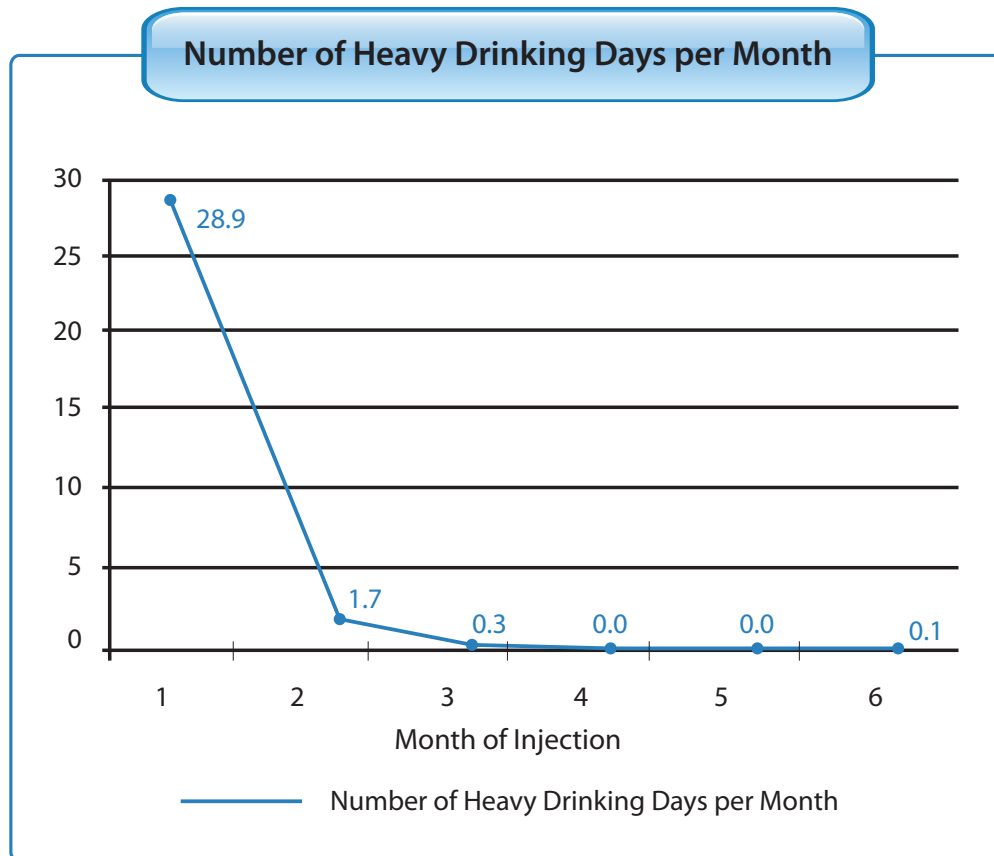
## The business case for MAT

*The estimated expense to society of opioid addiction nears \$20 billion annually, yet the cost of treating an individual addicted to opioids is only \$4,000 per year. If every opioid-dependent person in the United States received treatment, \$16 billion would be saved every year.*

*National Drug Court Institute Practitioner Fact Sheet  
"Methadone Maintenance and Other Pharmacotherapeutic Interventions in the Treatment of Opioid Addiction." April 2002, Vol. III, No. 1*

In the business world, a business case justifies offering a new product or service by evaluating the potential costs, risks, and benefits. Medication-assisted treatment not only improves client outcomes and transforms lives; it also can be more cost-effective than other forms of treatment.

Advancing Recovery Florida implemented MAT with Vivitrol® at three sites. This graph shows the dramatic drop in average drinking days after just one injection.



## ***Case Study: Making the Business Case for MAT*** **Advancing Recovery Maine**

The Addiction Resource Center (ARC), part of Mid Coast Hospital in Brunswick, Maine, developed a strong business case for offering on-site buprenorphine services.

In 2007, ARC took a snapshot of opioid-addicted clients entering treatment. In February, 20 clients diagnosed with opioid dependence completed screening and intake to enter treatment. Five of the 20 clients made their first appointment for treatment after their psychosocial assessment. Staff spent an average of two hours per client trying to find a prescriber for buprenorphine. A community prescriber accepted all five clients for buprenorphine induction. The remaining 15 clients were “lost” and did not attend any treatment sessions.

In short, only 25 percent of those who completed screening and intake were treated. The five clients who entered treatment required 20 hours of clinical assessment that month and 40 hours of phone and referral work.

Basic revenue = \$1,541.25 (20 assessments plus five initial Intensive  
Outpatient Treatment sessions)

Basic direct cost = \$1,260.00 (60 hours at an average rate of \$21.00/hr.)

Return on investment: \$281.25

Treatment engagement outcome = 25%

In the first month that ARC implemented MAT with buprenorphine, 34 opioid dependent clients were screened. Twenty-nine of these 34 clients attended the first treatment session, representing an 85% assessment conversion rate. Bringing a buprenorphine prescriber in-house relieved clients’ withdrawal and craving more rapidly, which helped them stay engaged in treatment and made the intervention more effective.

Basic revenue = \$6979.50 (34 assessments + 29 inductions + 29 IOP days)

Basic direct cost = \$2744.00 (34 counselor hrs + 29 MD hrs.)

Return on investment = \$4,235.50

Treatment engagement outcome= 85%

ARC found buprenorphine treatment was cost effective and it improved client outcomes.

Says one staff member, “Clients did not stay in treatment before we offered this service. We worked twice as hard for half the revenue and had worse outcomes. With MAT, you feel like you have effective tools at your side.”





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## Securing buy-in from your board and staff

While MAT has been shown to improve lives, families, and by extension, communities, treatment organizations face multiple barriers to implementing MAT, both internally and externally.

The board of directors or other governing group for an organization may need to be convinced of the benefits of an MAT program. In West Virginia, Pretera Center's staff gave the board of directors outcome data from programs around the country that were showing remarkable results, along with personal recovery stories from individuals who had tried and failed many times to sustain their recovery from opiates with traditional therapies. Presenting these outcomes with a well-thought-out business case helped to convince board members that the MAT approach to treating addiction was in the best interest of the agency, the individuals, and the community.

Administrative and clinical staff trained in the abstinence-based approach to substance abuse treatment and recovery may dismiss MAT as "replacing one drug for another." Educating staff on the benefits of MAT may need to be an initial focus for many organizations. Some of the most experienced addiction professionals were trained in the abstinence-based era. Helping staff understand how their clients will benefit from MAT is key to securing their buy-in.

***Case Study: Building staff buy-in***  
**Advancing Recovery Florida**

Spectrum Programs, Inc. (SPI) and Miami Behavioral Health Center provide community mental health, substance abuse treatment, and prevention services throughout Miami-Dade and Broward Counties. The two agencies have served more than 200,000 individuals.

SPI was one of three organizations in the Advancing Recovery Florida partnership, which aimed to increase use of Vivitrol® for alcohol dependence.

The agency discovered that client resistance to using the medication related in part to advice from the residential treatment technical staff, many of whom were in recovery and were firm believers in the abstinence-based approach. The SPI team arranged for a special training workshop for the tech staff, focusing on Vivitrol® as a medication that treats addiction as a brain disease.

After the training, the tech staff were more accepting of MAT, stating  
“Vivitrol is for the brain and the 12 steps are for the soul.”

“Everyone who touches the process has to be involved,” says Rhonda Bohs, Vice President of Banyan Health Systems, a partner to SPI. “We were focused on educating clients and the clinical professional staff. But by not training the para-professionals and the informal leaders, we were working against ourselves.”

## ***Case Study: Changing staff beliefs through education Advancing Recovery Maine***

Advancing Recovery Maine sought to dramatically increase access to and retention in MAT services. The project began by assessing the need for staff education. Maine's Single State Agency and the state provider association, ([www.masap.org](http://www.masap.org)) conducted two focus groups on competency and staff buy-in. The first focus group was with program executives and clinical supervisors, and the second was with direct-service staff. The results were aggregated across the state and for each participating organization. They showed that each agency had both supervisory and line staff who were uneasy with MAT services.

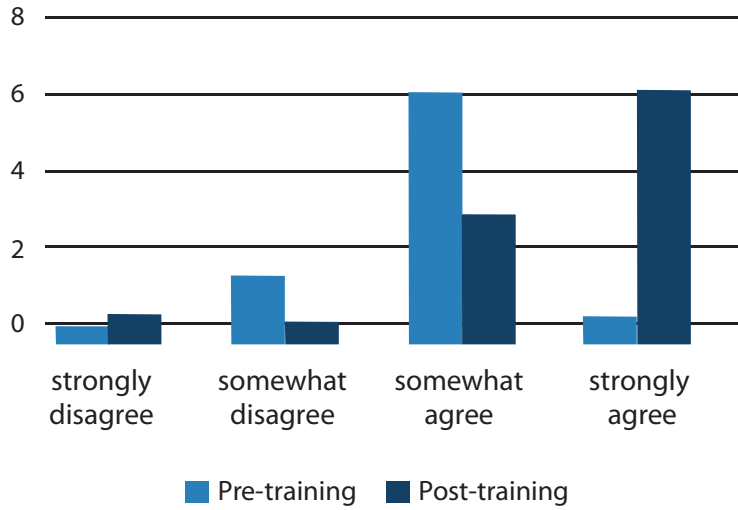
One treatment agency, the Addiction Resource Center (ARC) in Brunswick, Maine, began to survey staff annually to quantify the need for MAT training, using questions such as these:

- Do staff understand the need or gap in services?
- Do staff understand the clinical implications of the change on their work?
- Will clients be different from the ones we treat now?
- Does staff have the requisite knowledge, tools, and equipment to be successful?
- Have we provided pertinent data, background information, training, and coaching to assure buy-in, understanding, and confidence in their ability to do the work?
- Have the new competencies been incorporated into orientation and preception systems?

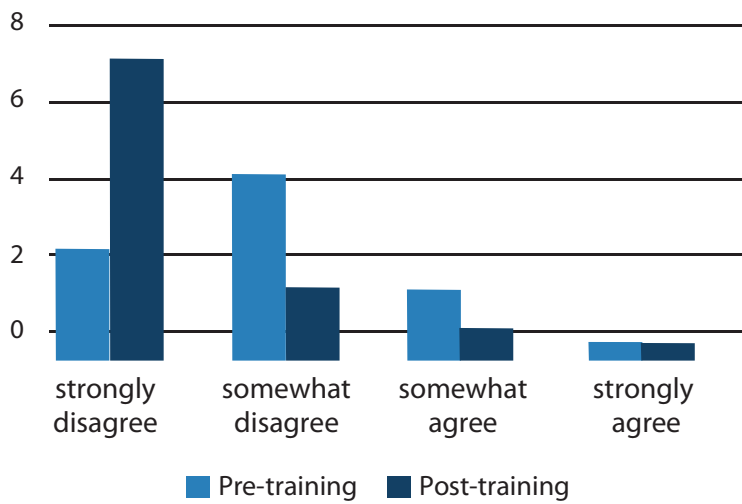
Depending on the results of the survey, ARC provides competency training in the neurobiology of addiction, signs and symptoms of over sedation and withdrawal (alcohol, opiates, benzodiazapines), benefits of urine drug screens, pregnancy and addictions, and using appropriate staging and grading tools.

The charts on the next page illustrate the change in staff beliefs before and after training in medication-assisted treatment at ARC.

**MAT allows patients to better control drinking addiction.**



**I do not support MAT because of poor patient compliance.**



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## Overcoming community resistance

Beginning to treat individuals with buprenorphine/suboxone can be controversial within a community. One strategy for overcoming community resistance is to share success stories with local papers and other media. What follows is one example from Advancing Recovery West Virginia.

### *Case Study: Building support for MAT through local media* **Advancing Recovery West Virginia**

Editorial featured in the Friday, December 11, 2009, edition of the *Charleston Gazette*, written by Bob Hansen, Executive Director, Pretera Center.

OxyContin®, Percocet®, and other opiates have become the drugs of choice in West Virginia. Nearly one out of five West Virginians in substance abuse treatment uses opiates like OxyContin®. In fact, our state has the fastest growing rate of opiate addiction in the country.

How can West Virginia reduce opiate addiction among its residents? The traditional treatment has been 12-step programs that rely on abstinence alone. However, a growing body of research also supports the use of medications like buprenorphine as a key component in effective treatment of addictive disorders. Our state is a pioneer in this promising practice, thanks to a project called Advancing Recovery West Virginia supported by a \$3.5 million dollar grant from the Robert Wood Johnson Foundation. As the director of the Pretera Center, which took part in Advancing Recovery, I've seen firsthand what a difference this new approach can make in fighting drug addiction.

Our goal when we launched our project in January 2008 was clear but ambitious: Help West Virginians overcome opioid addiction by removing barriers to medication-assisted treatment. Our strategy combined medication-assisted treatment with therapy and counseling. Pretera Center for Mental Health Services led the effort, working in partnership with the West Virginia Division on Alcoholism and Drug Abuse, Seneca Health Services, Valley Health Care System, and Westbrook Health Services.

By working together, our agencies could produce statewide results. Collectively, our four partnering agencies provide substance abuse services to more than 40 percent of West Virginia's 55 counties and to 49 percent of the population of the state.



*Overcoming community resistance*

Our project was founded on the research-based perspective of addiction as a chronic disease similar to other chronic diseases such as type II diabetes, cancer, and cardiovascular disease. Ongoing research by the National Institute on Drug Abuse and others adds to the evidence that addiction is a treatable medical disorder rather than a moral failing. Our first step: Educate staff and physicians—many of whom have always taken an abstinence-based approach to treatment—about the benefits of using buprenorphine in medication-assisted treatment. Some health care professionals view medication-assisted treatment as substitution—replacing one drug with another. Yet these same providers have also seen how the abstinence-based approach that worked for middle-aged alcoholics is failing the growing number of younger people struggling with opiate addiction.

Over the course of our project, the skeptics changed their minds when they began to see how medication-assisted treatment, combined with counseling and supportive services, worked for people they had not been able to help in the past. More than one clinician has described the results produced by this approach as “miraculous.”

Identifying physicians willing and able to prescribe medication for opioid addiction was also a challenge. Some doctors were opposed to treating patients struggling with substance abuse. But we were able to point out that “those people” are quite likely their patients already—just not revealing their addiction problems.

We’ve made good progress in educating physicians. When Advancing Recovery West Virginia began, just three doctors among the four participating providers were certified to prescribe buprenorphine. Today, thanks to education and outreach efforts to the medical community, nine doctors are using medication-assisted therapy, including five at Prestera, one at Valley, one at Westbrook, and two at Seneca.

Treatment alone isn’t enough. People in recovery, including those addicted to opiates, need fellowship and support from others. Many clients in medication-assisted treatment, however, were reluctant to attend traditional 12-step support groups, where the use of medication is not accepted as part of a recovery-based lifestyle. We overcame this barrier by working with the West Virginia Peer Recovery Network to create medication-assisted recovery support groups. Participants in these groups say they provide recovering clients with the fellowship and support they need while following a 12-step program in an environment that endorses medication-assisted treatment.



*Overcoming community resistance*

Over 18 months, we not only began to change how our state's health care system treats opiate addiction, we also changed hundreds of lives for the better. Our project provided medication-assisted treatment to nearly 1000 patients. Not only were we able to increase access to care, but we also reduced waiting times and the client no-show rate for services. Opiate addiction remains a huge problem in West Virginia and we must employ every tool available to us. Advancing Recovery West Virginia has shown that medication-assisted treatment can make a difference. We must extend this service more broadly across our state.

## ***Case Study: Advocating for MAT for adolescents*** **Advancing Recovery Texas**

Janet Anselmo-Hensen manages all of the substance abuse treatment services for the Dallas County Juvenile Probation Department. The department offers services ranging from screening and assessment to residential drug treatment for approximately 3000 patients, aged 10 through 17, each year.

Anselmo-Hensen first heard of “cheese heroin” in 2004, when a teenager in detention mentioned it to a chemical dependency specialist. Cheese heroin is a mixture of Tylenol P.M. and heroin. Users call it “cheese” because it looks like Parmesan cheese.

“All of the sudden it exploded in 2005,” says Janet. “Kids were mixing black tar heroin with any kind of over-the-counter pain medication.” This combination caused a string of deaths among adolescents in the Dallas-Fort Worth area. “The worst thing about it was that it was being marketed to 13- to 15-year olds as an inhalable form of heroin,” Janet explains. In 2005, Janet began to learn about medication-assisted treatment for adolescents addicted to cheese heroin.

“I checked with other adolescent treatment providers to find out what kind of treatment they were offering and what was appropriate for teens.” She also did research for best practices for opioid dependence. “Studies and randomized clinical trials were showing medication-assisted treatment with buprenorphine, combined with counseling, as safe and effective.”

“Our community leaders, commissioners, and the county board were not in favor of MAT for adolescents, and neither was I. But then I started to read about buprenorphine. And I saw just how miserable the kids were. They simply could not get clean, went through horrible withdrawals, and were snorting again as soon as they finished six months of residential treatment.”

With the medication, opioid-dependent teens could make it through the discomfort of withdrawal without giving in to the craving to use again and gain a toehold on recovery.



  
*Overcoming community resistance*

“Money for residential treatment that was not proving effective for our kids would be much better spent on medication-assisted treatment—which was showing miraculous results in the adult population.”

*Janet Anselmo-Henson, Dallas County Juvenile Probation Department*

Janet quickly became adept at describing the effectiveness of the medication. She also raised awareness of the cost of medication compared to residential treatment. Armed with an elevator speech on the benefits of medication, Janet talked to everyone she could. “I’d tell them that medication was the answer to the cheese heroin problem and would add the names of those interested to my e-mail list.”

Janet was also keeping her director informed. “I was constantly feeding him information on providers who were using MAT with adolescents.”

With her director’s permission Janet set up a meeting to discuss MAT with local treatment providers, leaders from school district, local hospitals and the department of public health. Out of that meeting in 2007 came a task force that helped Janet gain support for an MAT program from the Juvenile Board and county commissioners.

## *Case Study:* **Building statewide support for MAT Advancing Recovery Maine**

The Maine Office of Substance Abuse (OSA) and the Maine Association of Substance Abuse Programs (MASAP) collaborated on the state's Advancing Recovery Project.

Together they created the Maine Alliance for Addiction Recovery (MAAR) to engage the recovery community.

OSA worked with MASAP and MAAR to conduct a series of surveys and focus groups with providers and the recovery community in the first year of the grant. These efforts identified beliefs and attitudes toward the use of MAT as well as the challenges that both providers and clients face in successfully implementing MAT services.

A general survey of recovery communities produced more than 100 anonymous responses that MAAR posted on its web site. MAAR also posted data from focus groups and surveys conducted at AR pilot agencies and methadone clinics.

The focus groups created spirited discussions about stigma and discrimination that people face on all recovery paths. They also discussed:

- The importance of people with long-term recovery using their experiences to lessen stigma and discrimination
- The need people in recovery have for positive recovery role models
- The need for community-based recovery support in all areas of the state

Participants described these group forums as empowering, noting that no one had ever sought their opinions on these topics. Recovering people can work publicly, using their recoveries to educate policy makers and state leaders about recovery experiences and needs.

Providers in the Advancing Recovery Maine project used these results to address staff attitudes toward MAT. The results also informed the continued collaboration between OSA, MASAP, and MAAR in identifying and providing training events statewide. OSA worked closely with MAAR throughout the grant-funding period to identify ways to expand recovery support statewide.

## Paying for MAT

Insurance coverage should be the first place you look to pay for MAT for most patients. Many people who seek treatment have some kind of third-party coverage. Their insurance formulary may include the medication, and it may be easier for them to obtain medications than counseling. As parity regulations take effect and as health reform is implemented over the next few years, more people will have coverage that covers substance abuse medications.

Does your grant allow paying for medications? In many cases, medication is an allowable cost in state or block grant funds. Using grant funds to purchase medication may require some budget adjustments on a treatment agency's part, but in terms of cost per outcome, may be worth it.

Some state Medicaid formularies may require pre-authorization for payment of certain medications such as Vivitrol®, the injectable form of naltrexone. If pre-authorization for a medication is required, you'll need to understand the process and the criteria for the authorization process.

Does your grant allow paying for medications? In many cases, medication is an allowable cost in state or block grant funds. Using grant funds to purchase medication may require some budget adjustments on a treatment agency's part, but in terms of cost per outcome, may be worth it.

Are state or drug company programs available to pay for medications? Some states have low-cost drug programs for people who are low income but not eligible for Medicaid. Drug companies also sponsor programs to provide free or low-cost medication to patients who can't afford it. Each company has its own program so requirements will vary, but this information is available on manufacturer's websites or can be obtained from the company's sales people.

A state or pharmaceutical company's patient assistance program often requires detailed paperwork and documentation. Dedicating a staff person or a portion of a staff position to completing and submitting the paperwork usually results in a much speedier and more effective process than spreading the responsibility among staff. An administrative support position who could work with physicians, nurses, and other clinical staff may be an ideal candidate.

States may also re-allocate existing funding or seek new state resources to pay for medications. Examples include:

*Advancing Recovery West Virginia worked with its Single State Authority to secure \$75,000 to subsidize a portion of the costs for medication, physician, and lab fees.*

*Advancing Recovery Florida reallocated \$65,000 in existing state funds to purchase Vivitrol® using the state's Indigent Drug Program.*

*The Advancing Recovery Missouri project helped pave the way for legislation passed in 2009 that added funding for MAT to the state budget. In addition, providers who do not offer MAT risk losing their contracts with the state.*

*The state of Colorado also approved funding in 2010 to pay for MAT, based in part on the work of the Advancing Recovery Colorado partnership.*

*In Texas, provider and SSA authorities lobbied for the successful passage of a bill in the state's legislature to approve MAT on the Medicaid formulary.*

The state-operated mental health system is usually able to purchase medications at a discounted fee. Purchasing medications through the state mental health system for state-funded treatment providers can reduce the cost of the needed medications.

Linking patients to a Federally Qualified Health Center (FQHC) for ongoing MAT and primary care can also reduce the cost of medications. FQHCs receive substantially discounted rates on medications through a program titled 340B. At least 50 percent of the patients must be covered by Medicare or Medicaid. This requirement means that FQHCs are not likely partners for treatment agencies with many uninsured clients. Still, creative agreements may be possible. For example, the treatment provider may be able to reimburse the FQHC for medications at the discounted rates.

Patients may be asked to purchase medications. If no payment source is available to the treatment provider, many individuals and/or family members are willing to pay these costs when psychosocial treatment will be provided at no cost or at a discount.

Many for-profit methadone treatment organizations rely on private pay as their primary income. In fact, a business case could be made for the patient and family. The cost of the medication may be far less than the weekly costs of the alcohol or illicit drugs and the individual's health and quality of life may be significantly improved.

***Case Study: Building relationships with drug companies,  
funding sources, and pharmacies  
Advancing Recovery Colorado***

Advancing Recovery Colorado (AR Colorado) was a partnership between Signal Behavioral Health Network, a managed service organization that disburses and manages public funds for addiction treatment to a network of 20 providers serving 35 Colorado counties; the state's Division of Behavioral Health (DBH); and four treatment providers: Denver Health Behavioral Health Services, Arapahoe House, ARTS, and Arapahoe Douglas Mental Health. This partnership aimed to increase the use of oral naltrexone, and its injectable form, Vivitrol®, to help address the state's alcohol abuse problem.

AR Colorado was able to move forward with implementing MAT when Alkermes, the manufacturer of Vivitrol® donated approximately \$70,000 worth of the medication that would be shared equally by the participating providers.

Later in the project, AR Colorado used free samples available from the Alkermes and its patient assistance program to supplement the donations, while making the transition to more sustainable funding such as Medicaid and the state's MAT pilot.

“The local Alkermes rep was very helpful throughout the entire process. He never over-hyped Vivitrol® and helped with training. I would recommend to others implementing MAT that they develop a relationship with the drug manufacturer.”

*Erik Stone, Signal Behavioral Health*

Another challenge that AR Colorado faced was in storing the medication properly. Vivitrol® must be refrigerated in a pharmacy refrigerator. Since the participating providers did not work with pharmacies, the partnership brought in a fourth provider, Arapahoe Douglas Mental Health, which has its own pharmacy. Alkermes sent the Vivitrol® kits to this pharmacy, where it was stored until delivery to the other providers.

Denver Health's Behavioral Health Services (BHS) encountered some staff resistance to use of Vivitrol®, with nursing staff expressing concerns about the size of the injection and side effects that patients might experience. Staff attitudes changed over the course of the project, says Ron Gowins, (BHS) Substance Use Disorders Services Team Leader. "Staff began to see Vivitrol® and other addiction medications as tools to help people in recovery, and as an adjunct to counseling."

An average of over 16 clients per month received Vivitrol® during the second year of the project, a significant increase as the providers involved had never before used the medication with their clients. Over 90 percent of clients reported that medication helped them in their recovery from alcohol dependence.

In 2010, the state of Colorado also approved funding to pay for MAT, based in part on the work of the Advancing Recovery Colorado partnership.

## ***Case Study: Using a partnership of the state and providers to advance MAT Advancing Recovery Missouri***

Advancing Recovery Missouri was a two-year partnership between the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse (ADA), and 10 certified, contracted substance abuse treatment providers located throughout Missouri. The Missouri ADA is the single state agency (SSA) responsible for administering federal and state funds for drug and alcohol prevention and treatment.

Client data for 2005 clearly showed that for nine of the ten providers in the partnership, alcohol was most frequently used and abused by their adult clients. Because of this, in the first year of the project, AR Missouri chose to focus on removing barriers to the use of naltrexone and acamprosate to treat alcohol dependence. This evidence-based practice was judged to offer the greatest potential to benefit the largest percentage of Missouri consumers from all cultures, backgrounds, and socioeconomic levels.

AR Missouri discovered that the greatest barrier to using MAT was the state's not funding physician services in all programs or reimbursing providers for medication or laboratory services. These services must be available for the provider to use MAT. Adding reimbursement for physician time, medication, and laboratory services would dramatically increase the use of the MAT for alcoholism. The project planned to fund the services for MAT by reducing residential support services, where clinically appropriate to do so, but without reducing the intensity of treatment. Stabilizing consumers more rapidly through MAT and smoothing their transition to day treatment or intensive outpatient treatment would accomplish this. The project also created a centralized purchasing process, working with a state hospital that has a contract to purchase naltrexone. The ten participating providers were able to purchase the medication directly from the state hospital at a state contract price, 70 percent below retail.

The project provided training to increase knowledge and competence of clinical and medical staff in using MAT for alcohol dependence. The state's clinical utilization review unit added MAT to the criteria for extending length of stay or exceeding the customary service authorization.

Storing and dispensing medication presented a challenge for providers that had never dispensed medication before. Some providers contracted with a local facility or pharmacy to dispense the medication. Other programs used a community health clinic for prescribing and in the process, developed relationships with medical and pharmacy resources.

Because the Missouri Medicaid formulary includes naltrexone, clients with Medicaid could obtain the medication easily at a pharmacy. While these clients represent only a small percentage of the population that ADA serves, the ease with which they could obtain the medication assisted their recovery. The ten contracted providers implemented protocols to screen all patients admitted for alcohol treatment services for MAT. At the end of Year 2, almost 300 patients had been prescribed either naltrexone or acamprosate. Before the Advancing Recovery partnership, no patients were receiving either medication.

“If you have someone on Vivitrol®, they are much more likely to be able to maintain abstinence without having to be in a residential setting,” says Mark Stringer, director of the Missouri Division of Alcohol and Drug Abuse. This kind of cost offset, as well as the expected reductions in cost to the rest of the health care system due to improved treatment outcomes, helped “sell” the legislature on the additional funding.

*Alcoholism & Drug Abuse Weekly, November 2, 2009*

Working together, the state and providers developed and improved a screening tool to determine patient appropriateness for medication-assisted treatment, increased awareness of the effectiveness of MAT for alcohol dependence, and most significantly, established a funding mechanism for physician, medication, and laboratory services.

The success of the Advancing Recovery Missouri project helped pave the way for legislation passed in 2009 that added funding for MAT to the state budget. Providers who do not offer MAT risk losing their contracts with the state.



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## Finding prescribers

Finding physicians willing to prescribe substance abuse medications may be one of the biggest challenges you face in implementing MAT.

If your program employs medical staff, you may already have the prescribing and dosing capacity you need. Medications that require an induction and stabilization period require more time from medical staff to begin with. Once patients are stabilized, you can conduct medication management in groups or very brief office visits.

As convenient as it is to be able to write prescriptions in-house, the capacity often reaches its limit quickly. Additionally, federal regulations limit the number of patients a physician can treat with buprenorphine. Many programs have developed referring relationships with physicians in the community as well.

The structure of family and general medical practices makes it hard for physicians to spend the time with each patient required in the induction process, so physicians are sometimes reluctant to take on new patients in this phase of treatment. The state of Vermont pioneered an approach in which the medical directors of treatment agencies, hospital-based physicians, and detox program physicians perform the labor-intensive phase of induction for buprenorphine and then refer patients to community physicians for maintenance. This model has also worked well with buprenorphine MAT in Maine. Using a substance abuse specialist for induction and a general practitioner for maintenance addresses the problem of capacity within the specialty care system and the community-based physician's concern about the time commitment.

Your program may not have access to a staff physician. Some organizations have resolved this issue by recruiting physicians in the community to prescribe medications. Another approach is to obtain permission to discuss the need for medication with the patient's primary-care physician. As staff of treatment agencies serve more young people with opiate addiction, they are surprised to find that many have a primary-care provider who could prescribe if they were aware of their patient's diagnosis.

Some ideas for finding prescribers:

1. Patient's own physicians
2. Local Federally Qualified Health Centers (FQHCs)
3. American Society of Addiction Medicine (ASAM) membership directory
4. The local AMA chapter. See if you can present at a meeting or conference, or if they will work with you to find physicians willing to provide MAT.
5. An high-level influential person from your Department of Public Health or state medical society. Ask this person to make an appeal to physicians on your behalf. (See Baltimore story below.)
6. The pharmaceutical company that developed the medication.  
A representative may also be able to help you recruit physicians.

***Case Study: Building support from many different stakeholders***  
**Baltimore Buprenorphine Initiative**  
**(BBI)/Advancing Recovery**

Dr. Joshua Sharfstein, then director of the Baltimore City Health Department, launched the Baltimore Buprenorphine Initiative (BBI) in 2006 to improve access to medication-assisted treatment for heroin addiction. The goal of BBI is to bring Baltimore’s treatment centers, community health centers, and primary care physicians together to:

- 1) expand access to treatment for addiction to heroin, the primary drug of abuse in Baltimore;
- 2) spread the cost of substance abuse treatment between the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the mainstream medical system; and
- 3) integrate substance abuse treatment with other medical care, allowing addicts to be treated for other medical conditions

Dr. Sharfstein recognized that support from key leaders and stakeholders would be essential to the project’s success. He also aimed to train as many Baltimore physicians as possible to administer buprenorphine.

Dr. Sharfstein asked then Mayor Martin O’Malley and Congressman Elija Cummings to write to every major hospital in the city and request their participation. Mayor O’Malley supported buprenorphine treatment and was later elected governor of the state. As governor, he has created a statewide buprenorphine initiative for the treatment of heroin addiction.

Dr. Sharfstein personally contacted all the hospital presidents and the directors of the city’s federally qualified health care centers to ask for their support. The response from the hospitals was positive, with many of the city’s hospitals submitting detailed plans for how they would train physicians to administer buprenorphine.

The Medical Society of Maryland came on board as a key partner, offering buprenorphine education to physicians, helping to eliminate barriers to physicians’ providing buprenorphine treatment.

Marla Oros was hired to direct the BBI. With a master’s degree in nursing and experience as an addiction consultant, Ms. Oros brought knowledge of and experience in working with leaders in the mainstream medical system.

Dr. Sharfstein then charged three key agencies with the task of implementing BBI:

- Baltimore City Health Department
- Baltimore Substance Abuse Systems (BSAS): the substance abuse authority for the city of Baltimore
- Baltimore HealthCare Access: an agency of the Baltimore City Health Department that assists with the transition from Medicaid fee-for-service to managed care—Maryland’s HealthChoice, which provides health care to most Medicaid recipients.

BBI/Advancing Recovery provided funds for nine treatment programs to provide buprenorphine treatment. Program directors met every month at a “Buprenorphine Provider Round Table.” The program directors’ leadership of the project was critical to its success. They were involved in forming and approving all the policies and procedures related to the project.

The Maryland Single State Agency (SSA) was a partner in the BBI/Advancing Recovery initiative and integral to extending buprenorphine treatment across the state.

Investing in leadership from multiple spheres of influence helped ensure the success of the BBI/Advancing Recovery initiative. This focus on leadership helped resolve implementation issues throughout the process. The project improved access by increasing the number of slots for buprenorphine treatment from 112 in 2008 to 506 in 2009. It reduced waiting time to treatment so that clients could receive medication within 48 hours of the first treatment appointment. The project streamlined processes and created new treatment models in response to client feedback, and also developed a set of clinical guidelines for using buprenorphine.

### Case Study: Making good use of physician time Advancing Recovery West Virginia

Genise Lalos, Director of Addiction Services, Pretera Center explains: “We had to find a way to make it feasible for our physicians to add 50 to 100 clients to their case load and see these clients every week while still being able to provide quality care that they felt good about. After much passionate discussion, we came to the realization that having the physicians see clients in groups was the most efficient way to use their time. We learned that clients found this to be the most efficient use of their time as well. Clients reported that they benefited immensely from questions asked by other individuals in the groups. Physicians also reported great satisfaction with these groups and stated that they believed clients were benefiting more from the group appointments.

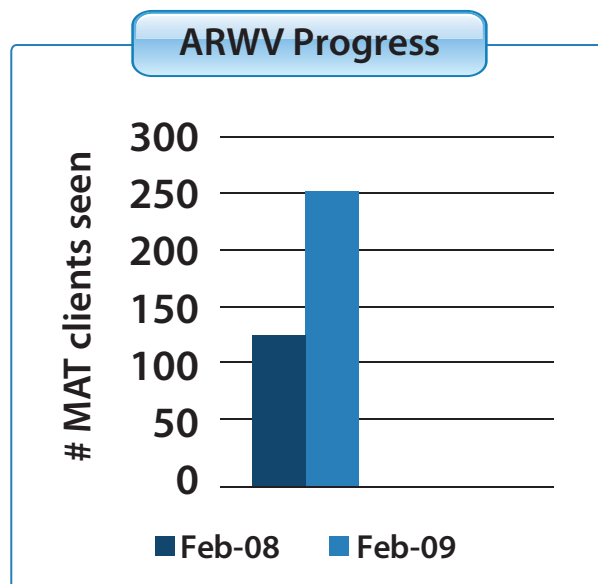
Pretera also added a full-time nurse position to assist physicians in managing their case load. Even though the services provided by this nursing position were not billable to any payer source, we found the position absolutely necessary because it helped our physicians be more productive. The nurse acts as a liaison to the client’s treatment team and has treatment information ready for the physician’s review, collects urine drug screens, co-facilitates the physician groups to keep the group on task and on time, works with the pharmacy to make sure that prescriptions are received, serves as an after-hours resource for clients with questions about side effects of their medication, and takes group notes for physician’s reference.”

Advancing Recovery West Virginia  
Aim: Improve access to Suboxone®  
for opioid dependence

Baseline data:  
February 2008: 128 patients  
receiving Suboxone® through the  
ARWV partnership

February 2009: 259 patients  
receiving Suboxone® through the  
ARWV partnership

Increase: 102%



## Licensing and credentialing

MAT services must meet state and federal regulatory requirements, which vary by state. In addition, national accrediting bodies such as The Joint Commission, The Commission on the Accreditation of Rehabilitation Facilities (CARF), and the Council on Accreditation (COA) play important roles in regulating safety and best practices in behavioral health care, with special sections dealing with opioid agonist therapy.

Before you develop your program, review your state's licensing standards. It is also helpful to visit other programs that are delivering a similar service to observe how they comply with licensing standards. Talking to staff at your state's licensing authority and single state agency while you are planning your MAT program will help you avoid pitfalls and comply with requirements.

Regulatory and accreditation activities fall into three main categories:

Patient Care, Operations, and Professional Certifications and Competencies.

1. Patient Care. This area includes access, patient rights and responsibilities, informed consent, assessment and triage, clinical documentation, and coordination of care. It includes medication reconciliation, crisis or safety planning, family involvement, special accommodations, prescribing, lab testing, and matching interventions to clinical presentations.
2. Operations. This area covers the physical plant (including fire and life safety codes), ADA, medication storage, dispensing, reconciliation, case load tracking and size, registration, and billing. It includes community outreach, education, and safety. Prescribing medications for opiate dependence requires a plan for reducing the risk of medication diversion.
3. Professional Certifications/Competencies. These activities relate to an organization's documenting that staff are qualified to provide treatment services. Agencies need to complete regular assessments of their staff and services to identify problem-prone areas and high-risk or high-volume activities. The assessment can help identify the types of training an agency needs to conduct. Competencies are established when there is a direct opportunity to evaluate (through testing, observation, or other methods) that professionals are transferring knowledge into practice. Many state and federal accreditation standards outline the MAT training and competencies staff must demonstrate.

## **Requirements for physicians prescribing buprenorphine: DATA 2000**

The Drug Abuse Treatment Act of 2000, DATA 2000 (Title XXXV, Section 3502 of the Children’s Health Act of 2000), allows physicians who meet certain requirements to provide treatment for opioid dependence in their office, using Schedule III, IV, and V narcotic medications that the Food and Drug Administration has approved. Physicians can prescribe and dispense these medications in treatment settings other than the traditional opioid treatment program setting.

Physicians are eligible to receive a waiver from the standard terms of the Controlled Substances Act after completing at least eight hours of training.

DATA 2000 authorized the following organizations to provide the training physicians need to complete to receive the waiver:

- American Academy of Addiction Psychiatry (AAAP)
- American Osteopathic Academy of Addiction Medicine (AOAAM)
- American Psychiatric Association (APA)
- American Society of Addiction Medicine (ASAM)

Physicians are allowed to treat 30 patients at a time during the first year but can apply for a waiver to treat 100 patients during the first year based on the degree of the opioid addiction problem in their state.

For complete information, visit:

[http://buprenorphine.samhsa.gov/waiver\\_qualifications.html](http://buprenorphine.samhsa.gov/waiver_qualifications.html)

## *Case Study: State licensing rules* **Advancing Recovery West Virginia**

Pretera Center was the lead organization for Advancing Recovery West Virginia, in partnership with three other providers and the state Bureau for Behavioral Health and Health Facilities (BBHFF).

On September 1, 2009, the West Virginia Office of Health Facility Licensure and Certification sent the Pretera Center an administrative order to stop prescribing buprenorphine. The order stated that the reason for this closure was that “Pretera Center for Mental Health Services is operating an opioid treatment program offering Suboxone® as a replacement for illegal drug dependence. However, Pretera failed to obtain a license to operate an opioid treatment program.”

None of the ARWV partners held the OTP license, and the state had imposed a moratorium on licensing any new OTPs. The Administrative Court order gave Pretera Center 30 calendar days to cease operating their office-based buprenorphine program. As a result, ARWV stopped admitting new patients into the MAT program and began titrating patients off of their medication.

Closing all of the ARWV MAT programs entirely would leave 500 patients with no access to treatment and medication, placing them at risk for relapse or even death. In response, distraught consumers and their family members called the governor’s office and the media. Local and national experts rallied in support of ARWV’s office-based buprenorphine program. The ARWV partners also provided the Licensure and Certification office with accurate information on the regulations for prescribing buprenorphine.

The Drug Addiction Treatment Act of 2000 (DATA 2000) expands the clinical context of medication-assisted opioid addiction treatment by allowing qualified physicians to dispense or prescribe specifically approved Schedule III, IV, and V narcotic medications for the treatment of opioid addiction in treatment settings other than the traditional Opioid Treatment Program (i.e., methadone clinic).

<http://buprenorphine.samhsa.gov/>

Although funding for the ARWV MAT program ended in June 2010, the partnership has continued to offer office-based buprenorphine. The project leaders have also done outreach to increase awareness and secure buy-in from the treatment community, the criminal justice system, and physicians.



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## Screening and assessing

Most organizations follow a similar process to assess a client's type and severity of drug or alcohol abuse, using a variety of validated screening tools. The process identifies key factors to weigh in selecting the most appropriate medication for each client.

The first step is to determine the patient's health and safety. Chronic use of opioids, alcohol, and other drugs can cause serious withdrawal symptoms. Many clients seeking addiction treatment are addicted to more than one substance. The initial screening may indicate that the person should go to the closest emergency department or detoxification unit, call 911, or make an appointment for an assessment.

Information that you gather on the client's symptoms, pattern of use, consequences of use, co-occurring conditions, and previous treatment, will determine appropriate interventions. Screening tools that offer standardized patient placement criteria include:

- ASAM-PPC-2R: American Society of Addiction Medicine's Second Edition-Revised of Patient Placement Criteria
- ASI: Addiction Severity Index
- AUDIT: Alcohol Use Disorders Identification Test
- CIWA-AR: Clinical Institute Withdrawal Assessment
- COWS: Clinical Opiate Withdrawal Scale
- DAST: Drug Abuse Screening Test
- GAIN: Global Appraisal of Individual Needs
- LOCUS: Level of Care Utilization System

In addition to screening results, factors such as the client's ability to self-administer medications, adhere to régimes, participate in treatment/counseling services, and pay for professional fees and medications influence treatment options. Risk factors to consider in screening include the potential for medication diversion, medication interactions, and contraindications for medication choices in light of existing medical and or psychiatric conditions. For example, the antagonist medication naltrexone or Vivitrol® is contraindicated for an alcoholic patient with chronic pain taking an existing analgesic or a patient with acute hepatitis or liver failure. Patients may need to undergo laboratory tests to determine whether physical problems should prevent the use of specific medications.

## ***Case Study: Addiction Resource Center (ARC), Mid Coast Hospital, Brunswick, Maine A Medication-assisted Treatment Model***

The Addiction Resource Center (ARC) at Mid Coast Hospital has a medication-assisted treatment (MAT) model designed to give clients the chance to stabilize from opiate dependency and continue their recovery.

ARC selects clients for buprenorphine MAT based on American Society of Addiction Medicine (ASAM) criteria and published best-practice standards. Clients are expected to engage fully in treatment and make a commitment to observing all ARC and Mid Coast standards, rules, and expectations.

ARC conducts buprenorphine inductions with three to five clients at a time, over two consecutive days, Monday and Tuesday. Clients complete lab work before induction. A family member or friend who will be providing support throughout recovery may accompany the client for induction. Clients are instructed to arrive for the group induction in withdrawal on Monday morning, having abstained from all opioids for a minimum of 24 hours.

**Day 1 of Induction:** ARC staff meet with the group at 8:00 a.m. to review the risks and benefits of MAT and collect the clients' signed forms. A nurse or other practitioner assesses each client's withdrawal symptoms using the Clinical Opiate Withdrawal Scale (COWS).

A doctor reviews the clients' labs, assessments, vital signs, and COWS results, then meets with each patient to review the information. The patient obtains a prescription and is instructed to pick it up at a pharmacy (within walking distance of the clinic) and then return to the clinic. The patients take the first dose per the doctor's orders in front of nursing staff at the clinic. They are observed until the medication is dissolved under the tongue. Clients then return to their treatment program.

11:00–11:15: Patient receives second dose of medication. Staff assess patient again using COWS.

**Day 2 of Induction:** At 8:00 a.m. on Day 2 of induction, clients meet as a group and review their symptoms during the past 24 hours. A nurse or other practitioner administers the COWS inventory again. After a medication count, clients receive their next dose, then return to their treatment program.

In the weeks after induction, clients attend medication management groups for all medication follow-up. Clients are offered a range of times and days during the week for these 90-minute appointments.

Clients may be transferred to other prescribing physicians after they have “stabilized.” A stable client has consecutive negative drug screens and participates in groups consistently with no absences or cancellations.

The ARC medication-assisted treatment program operates in phases. After starting on buprenorphine, clients can participate in the most appropriate treatment program, which is often the Intensive Outpatient Program. Clients may always move up or down the phases as determined by their behavior, drug screening, and treatment attendance.

**Phase I: Evaluation/Stabilization.** This phase lasts a minimum of four weeks. Clients attend all required treatment sessions, provide random urine drug screens weekly, and attend one medication management each week. The doctor and counselor review drug screen results, treatment attendance, participation in self-help, and progress on treatment plan goals to determine when clients are ready to step down to Phase II.

**Phase II: Stabilization/Maintenance.** This phase lasts a minimum of eight weeks. Clients must attend all required treatment program sessions, provide random drug screens, and attend a medication management group twice each month. The doctor and counselor review drug screen results, treatment attendance, participation in self-help, progress on treatment plan goals, and positive interactions with peers in group sessions to determine when clients are ready to move to phase III.

**Phase III: Maintenance.** This stage can last as long as a client and his or her treatment team agree that the client needs medication-assisted treatment to sustain on-going recovery goals. Clients attend all required treatment program sessions, provide random drug screens, and attend medication management groups monthly.

**Phase IV: Taper/Discontinuation.** During this phase, a client works with his or her treatment team to develop a plan for tapering off the medication. This phase often requires an increase in counseling services. It’s not unusual for a client to resume medication after a first attempt to taper or discontinue. The treatment team is prepared to provide additional support.



*Screening and assessing*

Clients are encouraged to call ARC to discuss treatment side effects or any other issue related to their medication-assisted treatment. A therapist is on call for assistance after hours.

While many patients may need to remain on buprenorphine indefinitely, others may wish to taper off or discontinue the drug. Tapering or discontinuing may also be an administrative or clinical requirement if medication diversion or continued opioid use is an issue.

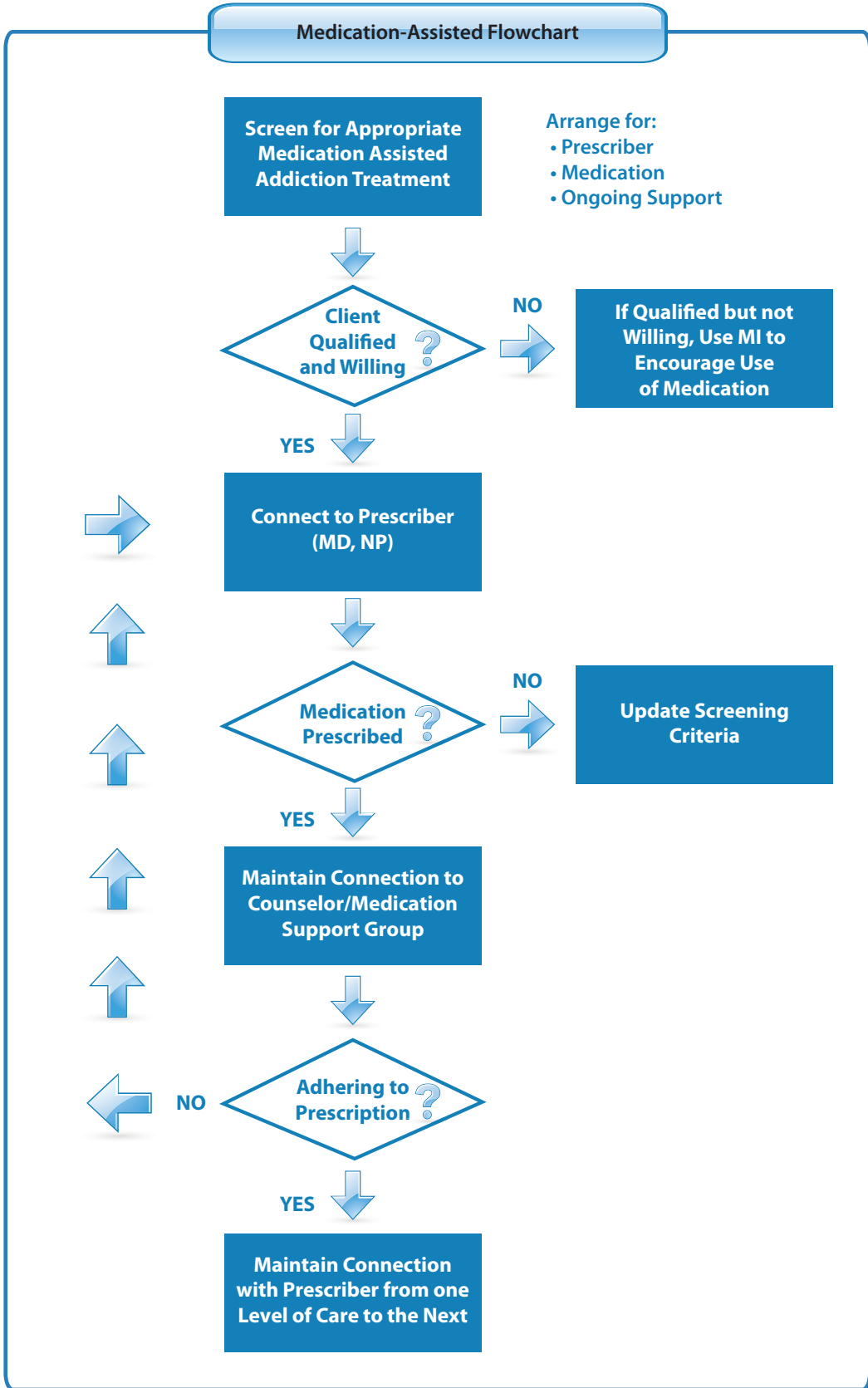
### *Case Study: Another MAT model* **Advancing Recovery West Virginia**

At Pretera Center in West Virginia, clients entering the Suboxone® program first receive an orientation about the program and the commitment they must be willing to make. Clients are required to attend weekly group therapy, individual counseling every other week. Weekly group therapy focuses on helping clients establish coping skills for recovery. Clients must also attend at least four 12-step meetings each week.

The program mission is to show clients they need to help themselves by making life changes and establishing a foundation for recovery, a process that will last the rest of their lives. Clients generally take Suboxone® for anywhere from six months to two years. Clients in these programs see a physician weekly and only receive enough medication to get them to the next week’s physician appointment.

Pretera staff conduct an instant urine screen on each client each week to test for the presence of Suboxone®. When Pretera first started this procedure, staff discovered that several clients were not using the Suboxone® they were prescribed.

Pretera also found that one of the local hospitals offers a lab panel called the “wellness panel” that costs \$25 and includes a CBC, a hepatitis panel, and a liver function test. Clients were advised to get their labs there because it was far less expensive than other lab services. Agencies need to check with local medical facilities for specials like this so that they can pass on the savings to the client.



## Combining therapy with medication

Patients taking medications to support their recovery from alcohol or other substance dependence also benefit from individual, family, or group counseling. Support from a 12-step group can be essential to an effective recovery program.

### *Case Study: A model of MAT with counseling* **Fayette Companies, Peoria, Illinois**

Fayette Companies in Peoria, Illinois, (<http://www.fayettecompanies.org/>), developed an outpatient Suboxone® program for opiate dependency. A team that included the vice president of quality improvement, medical director, and nurses and counselors from the detoxification and methadone programs designed the program.

The team decided to provide an evening intensive outpatient program (IOP) to accommodate patients' work schedules. The goal of the program was to provide detoxification, followed by ongoing cognitive behavioral therapy. The team adopted a 13-day titration schedule for detoxification from a NIDA clinical trial. Nurses and physicians at the detoxification unit conducted the initial physical exam and were also available to induct patients and prescribe medication.

Fayette Companies did not have any funding to provide Suboxone®. Patients without insurance were required to pay for their medication. Those who could not pay on their own obtained financial assistance from their families for the pharmacy costs.

Fayette Companies began to enroll patients in the program in the fall of 2006. The design team changed their role to function as a change team to oversee the program and make modifications as needed.

One of the first modifications was to the 13-day schedule for rapid detoxification. Patients would take Suboxone® in gradually lower doses over a 13-day period, and then go off the medication. Virtually none of the patients wanted this process to last only 13 days.

Patients made such statements as “I feel great now,” “I have my life back,” and “I’m getting my family back.” The team replaced the 13-day rapid detoxification schedule with an individualized approach that allowed for access to medication and therapy for a longer period.



*Combining therapy with medication*

After the first few weeks of the program, patients completed an evaluation. Most cited the inconvenience of having to attend IOP counseling sessions four evenings a week. Some were driving a distance of 50-60 miles. They requested more individual and family counseling. The staff and patients negotiated a plan to have shorter groups two evenings a week and more individual and family sessions. On evenings when groups were held, individual sessions would take place before or after the shorter group sessions.

Data collected on the first 170 participants indicated that 39% were dependent only on prescription opiates while another 22% were using both prescription medications and heroin. Fifty-one percent were diagnosed with a mental health condition. A psychiatrist assigned to work with the program diagnosed and prescribed psychotropic medications if needed. Family members were involved in the treatment for 59% of the participants. The median length of time receiving Suboxone® was 80 days. Less than 10% of patients decided to continue on a maintenance protocol. Patients on a maintenance protocol were transferred to continuing care that consists of a monthly physician visit and a monthly meeting with a counselor who assesses the patient's continued stability and addresses any emerging problems.

State funding was used to pay for the psychosocial treatment, and capacity was always filled. A self-pay option is being implemented for people without insurance to allow greater access. These people will be placed on a list for potential state funding if they meet income eligibility.



***Case Study: Customer input helps focus efforts  
Baltimore Buprenorphine Initiative  
(BBI)/Advancing Recovery***

Launched in February 2008 as part of the Baltimore Buprenorphine Initiative’s Advancing Recovery (AR) project, a partnership sought to remove barriers to medication-assisted treatment and improve continuing care among patients, both at treatment programs and at physicians’ offices. The partnership included the Maryland Alcohol and Drug Abuse Administration, Baltimore City Health Department, Baltimore HealthCare Access, Baltimore Substance Abuse Systems (BSAS), and three treatment agencies.

Treatment included dose induction, stabilization, and continuance on buprenorphine combined with intensive outpatient counseling (IOP). Following IOP, patients received extended buprenorphine therapy. Participating agencies transfer stabilized patients with pharmacy and health care benefits to physicians in community health centers and other settings.

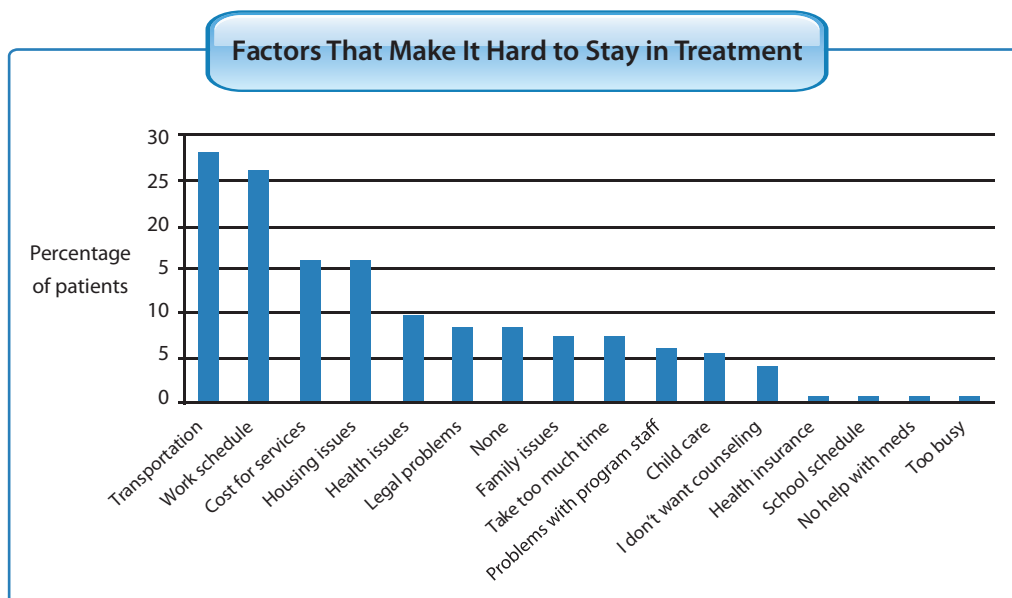
As part of the application project, BSAS reviewed its own intake process. One agency was able to reduce to a single form from 19 forms requiring patient signatures witnessed by a counselor. “That was a miracle for the staff,” says Bonnie Campbell, director of policy and planning. “Taking the focus off paperwork and funding regulations during the intake process allowed us to concentrate on engaging our clients in treatment.”

Making the intake process more manageable for clients, counselors, and administrative staff was part of BBI’s first targeted aim to reduce time to treatment. Through this and other work, the team reduced a patient’s waiting time from first request for treatment to first face-to-face contact. The work also reduced waiting time from first face-to-face contact to first medication dose.

Patient response to improved access was positive, says Campbell. Patients could get the medication on the same day or the next day, instead of three weeks. “Patients say that buprenorphine has changed their lives—now they can work and take care of their children.”

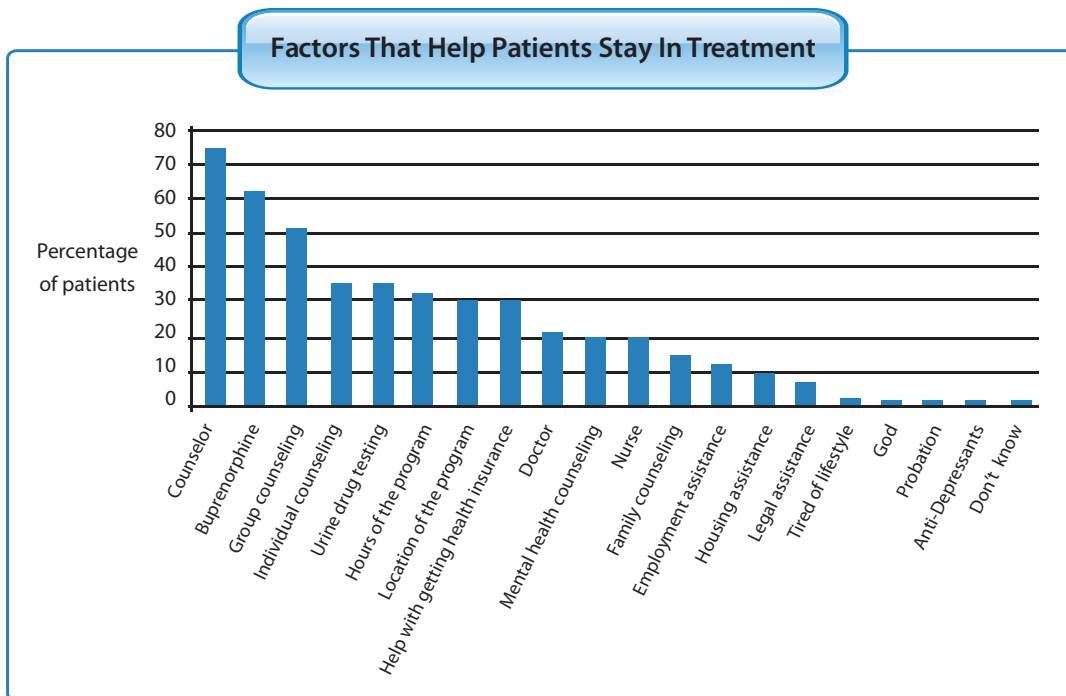
Reducing waiting time was expected to increase patient continuation in treatment. This did not happen, probably because patients interested in quick access to medication were more likely to be in acute withdrawal discomfort and less interested in intensive outpatient counseling.

To improve the IOP retention rate, the team conducted six focus groups of patients of clients at various agency sites. An independent facilitator conducted the groups. In addition, every client appearing for treatment over a two-day period at each of the sites was asked to complete a paper survey on their treatment needs. Telephone surveys of clients who had dropped out of treatment were also conducted.



Through these efforts, the team learned that clients thought the IOP required too much time. They cited transportation and work schedules as barriers to continuing in treatment.

The focus groups also revealed that clients were more interested in individual counseling and help with housing and job skills than in the educational content offered in the traditional group model. As a result, the project leaders began to use alternative treatment models that could include the requested services and counseling.



Client input was key in identifying barriers and how to remove them. “We learned that we need consumer input all along the way and that we can refocus our efforts depending on what feedback we get from clients,” says Campbell.

The AR team in Baltimore is building a body of resources about the effectiveness of MAT to share with the field. “We have developed standardized guidelines for providing buprenorphine in our publicly-funded clinics,” explains Campbell. “We are excited about what is emerging from the Advancing Recovery project—a uniform approach to distributing and monitoring the medication that other cities can adopt.”

# Sustaining your MAT program

## Duration of medication-assisted treatment

Addictions are chronic illnesses, and, like all chronic diseases, are not curable. Some alcoholics are able to discontinue anti-craving medications (naltrexone, Vivitrol®, Campral®) after they have achieved stable recoveries. People with opioid dependence may require long-term use of medications to maintain recovery because of the way opioid abuse changes the brain.

*Medication-assisted treatment of alcohol use disorders (AUDs) is consistent with treatment of other chronic disorders such as diabetes or hypertension. Long-term, perhaps indefinite, use of medication for patient stabilization is reasonable. Medication for AUDs may be employed indefinitely or intermittently along with interventions aimed at changing lifestyle practices to sustain recovery.*

From SAMHSA TIP 49: Incorporating Alcohol Pharmacotherapies into Medical Practice

*Although most patients would prefer to be medication free, this goal is difficult for many people who are opioid addicted. Maintaining abstinence from illicit opioids and other substances of abuse, even if that requires ongoing MAT, should be the primary objective.*

From SAMHSA TIP 43: Chapter 7. Phases of Treatment

## Maintaining recovery and access to medication

NIDA's Clinical Trial Network (CTN) continues to research the most effective dosage and duration for MAT. Findings repeatedly show that discontinuing medications according to arbitrary deadlines results in relapse. Research trials indicate that access to medications correlates strongly to clients' successful recovery. Feedback to counselors and prescribers about symptom abatement and side effects also supports continued access to medication.

Organizations that implement MAT need to consider how they can help clients obtain medications for optimal dosages and duration.

## Engaging the recovery community

Twelve-step programs such as Alcoholics Anonymous and Narcotics Anonymous vary in their stance on medication-assisted treatment. In some communities, recovery groups consider addiction medications as "substitutions" for the drug of choice rather than a form of treatment. Some of the Advancing Recovery partnerships (West Virginia and Maine) helped launch 12-step groups that welcomed members using medication. As awareness of effectiveness of MAT increases, more recovery groups support it as an effective component of recovery.

## Celebrating your MAT Program

Implementing an MAT program presents a unique set of challenges: securing buy-in from the staff and community; finding prescribers and ways to pay for the medication; and observing rules on dosing, administration, and regulation.

The hard work of launching an MAT program is well worth the effort. Patients recovering from addiction with the assistance of MAT often express how wonderful it is to be freed of the compulsion to use. Seeing clients get better and reclaim their lives is a joy. This is especially the case for clients who have had multiple relapses.

MAT also boosts the success that treatment staff have in their work, offering encouragement in a field plagued by high turnover and burnout. As one clinician says, “MAT allows us to save lives.”

Be sure to celebrate your success! Share outcomes and client recovery stories in your agency newsletter. Schedule a special event to describe the changes, share the results, and acknowledge staff efforts. This kind of public celebration helps keep your team motivated and educates others about the value of MAT.

Share treatment outcomes with your board of directors, local media, and your state government. Using medications can reduce costs associated with residential treatment and other expensive forms of treatment. Document the cost savings, potential reductions in other health care costs, and benefits to the community (reduced drug-related crime, increased employment, reunited families) and use this evidence to campaign for additional state funding for MAT.

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## The medications

The FDA has approved several medications that have been proven effective in treating people with alcohol or other substance use disorders. The medications are most effective when they are part of a comprehensive treatment program that includes behavioral counseling or therapy, the patient's active participation in a support group or 12-step program, and a long-term plan for managing the disorder.

Substance use medications (with the exception of disulfiram, or Antabuse®) are classified by how they target the opioid receptor sites in the brain: agonist, partial agonist, or antagonist.

Most opioids that are abused—heroin, morphine, and prescription opiates like OxyContin® and Vicodin®—are agonists. Agonists bind to the opioid receptors in the brain and activate them, producing a feeling of euphoria.

Partial agonists also bind to brain receptors, but do not produce the full effect of an agonist.

Antagonists bind to receptors but block rather than activate them. They prevent receptors from being activated by an agonist.

### For alcohol-use disorders

The first medication approved for alcohol use disorders, disulfiram (Antabuse®), is used in aversive therapy. Drinking alcohol after taking disulfiram causes severe discomfort, ranging from facial flushing to headache and vomiting.

Newer medications approved for treating alcohol dependence include acamprosate calcium (Campral®) and naltrexone (ReVia®, Vivitrol®, Depade®). These medications decrease craving, especially that related to protracted withdrawal.

### For opioid dependence

There are two forms of buprenorphine: Subutex® (pure "BUP") and Suboxone®. Suboxone® also contains naloxone, an opiate-blocking agent. Naloxone deters intravenous use of buprenorphine. If Suboxone® is injected, it will result in opioid withdrawal. It is often the choice for use in outpatient settings.

Methadone is a synthetic opioid that has been used to treat people with opioid addiction for more than 40 years. It has also been used as an approved narcotic painkiller. Methadone is available in liquid or tablet form. The SAMHSA Substance



*The medications*

Abuse Treatment Advisory, “Emerging Issues in the Use of Methadone” (Spring 2009, Vol.8, Issue 1) stresses that “methadone is effective and safe in the treatment of opioid addiction and chronic pain when it is used appropriately.”

Naltrexone, acamprosate, and disulfiram can be prescribed by nurse practitioners and physician assistants. Buprenorphine can be prescribed only by a physician who has taken an eight-hour training course and received a special DEA license number. For complete information on physician requirements for prescribing buprenorphine, visit: [http://buprenorphine.samhsa.gov/waiver\\_qualifications.html](http://buprenorphine.samhsa.gov/waiver_qualifications.html)

Vivitrol<sup>®</sup>, which is now approved to treat opioid as well as alcohol addiction, the injectable form of naltrexone, is usually administered by a nurse or other qualified practitioner.



## FDA-Approved Medications for Substance Use Disorders

Medication name	Treatment use:	Trade name	How the medication works	How it's administered	Special licensing or credential required?	Year approved by FDA	Physician training required?
Acamprosate Calcium	alcohol use disorder	Campral®	Reduces cravings by reducing symptoms of protracted alcohol withdrawal.	Oral; Two tablets three times a day	No	2004	No
Disulfiram	alcohol use disorder	Antabuse®	Aversive; causes severe physical discomfort if patient consumes alcohol.	Oral, tablet	No		No
Naltrexone	alcohol use disorder; opioid dependence	ReVia®, Vivitrol®, Depade®	By blocking opioid receptors, it blocks cue-triggered craving and decreases the euphoric effects of alcohol.	Two forms: a once daily oral tablet, and Vivitrol®, an injectable form taken once a month	No	1994; Vivitrol® for opioid dependence in 2010	No
Buprenorphine	opioid dependence	Suboxone®	A long-acting partial opioid, it relieves withdrawal, decreases craving, and prevents euphoria if other opioids are used.	Tablet taken sublingually once daily; sublingual film approved August 2010.	Varies by state	2002	Yes—8 hours of training required
Methadone	opioid dependence		A long-acting "full" opioid that relieves withdrawal, blocks craving, and prevents euphoria if other opioids are used.	Oral solution	Yes	Approved dispersible tablet for treatment of addiction	No

### Alcohol Use Disorder (AUD) Medication Decision Grid\*

Pretreatment indicators	Acamprostate® (Campral®)	Disulfiram (Antabuse®)	Oral Naltrexone (ReVia®, Depade®)	Injectable Naltrexone (Vivitrol®)
Renal failure	X	A	A	A
Significant liver disease	A	C	C	C
Coronary artery disease	A	C	A	A
Chronic pain	A	A	C	C
Current opioid use	A	A	X	X
Psychosis	A	C	A	A
Unwilling or unable to sustain total abstinence	A	X	A	A
Risk factors for poor medication adherence	C	C	C	A
Diabetes	A	C	A	A
Obesity that precludes IM injection	A	A	A	X
Family history of AUDs	A	A	+	+
Bleeding/other coagulation disorders	A	A	A	C
High level of craving	A	A	+	+
Opioid dependence in remission	A	A	+	+
History of postacute withdrawal syndrome	+	A	A	A
Cognitive impairment	A	X	A	A

A = Appropriate to use

X = Contraindicated

C = Use with caution

+ = Particularly appropriate

Source: Center for Substance Abuse Treatment. Incorporating Alcohol Pharmacotherapies Into Medical Practice. Treatment Improvement Protocol (TIP) Series 49. HHS Publication No. (SMA) 09-4380. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009, Page 52. <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A92752>

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## Pregnant women and medication-assisted treatment

For women with alcohol use disorders, the anti-craving medications naltrexone (Vivitrol®) and acamprosate (Campral®) are not recommended for use during pregnancy.

For pregnant women who need treatment for opioid dependence, opioid agonist therapy with medication is a medical necessity. The standard of care currently is to recommend methadone maintenance, but if this is not available or if the patient strongly objects, buprenorphine is an accepted alternative. Buprenorphine is rapidly being recognized as safe and effective in treatment with better neonatal outcome. Many doctors who treat pregnant, opiate-addicted women prescribe buprenorphine.

For more information, review the guidelines provided by Physician Clinical Support System at: <http://www.naabt.org/documents/PCSSPregnancy.pdf>

**Sample Forms from the Addiction Resource Center (ARC),  
at Mid Coast Hospital, in Brunswick, Maine**

- 1. Patient Responsibilities–Buprenorphine Maintenance treatment . . . . . 49
- 2. Standing Order-set for Suboxone/Subutex Induction and Maintenance . . . . . 50
- 3. Checklist for Buprenorphine Induction . . . . . 51
- 4. Suboxone Administration/Documentation Competency . . . . . 52
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## Sample Form Patient Responsibilities Buprenorphine Maintenance Treatment

- \_\_\_\_\_ You agree to store the medication properly. Medication may be harmful to children, household members, guests, and pets. The pills should be stored in a safe place, out of reach of children. If anyone besides the patient ingests the medication, the patient must call the poison control center or 911 immediately.
- \_\_\_\_\_ You agree to take the medication only as prescribed. The indicated dose should be taken daily, and you must not adjust the dose on your own. If you want a dose change, call the clinic for an appointment.
- \_\_\_\_\_ You agree to comply with the required pill counts and urine tests. Urine testing is a mandatory part of maintenance, and you must be prepared to give a urine sample for testing at each clinic visit, as well as to show the medication bottle for a pill count as requested.
- \_\_\_\_\_ You agree to notify ARC immediately in case of lost or stolen medication. Medicine will not be prescribed earlier than scheduled.
- \_\_\_\_\_ You agree to notify the clinic immediately in case of a relapse to drug abuse. Relapse to opiate drug abuse can be life threatening, and an appropriate treatment plan has to be developed as soon as possible. Your physician should be informed about a relapse before a urine test shows it.
- \_\_\_\_\_ You review the description of maintenance at this site. This description includes the hours, phone numbers, procedure for making appointments, fees, the requirements for treatment attendance, and ARC's responsibilities for patient care.

PATIENT SIGNATURE \_\_\_\_\_ DATED \_\_\_\_\_

WITNESS \_\_\_\_\_ DATED \_\_\_\_\_

**Sample Form  
Standing Order-set for Suboxone-Subutex  
Induction and Maintenance**

Patient Label

Date Ordered	Time	Standing Order-set	Action Take Signature
		<input type="checkbox"/> Complete Level of Care Assessment	
		<input type="checkbox"/> Admit to appropriate level of care	
		1. Conduct initial OP office visit	
		2. Assess every hour with the Opioid Withdrawal Assessment Instrument	
		3. Laboratory: CBC, Hepatic Function Panel, Urine Drug Screen, HCG as Indicated, Hepatitis Profile	
		Suboxone Induction Orders:	
		1. DAY 1 COWS determination prior to beginning dosing.	
		2. Administer Suboxone 4 milligram sublingually, return to treatment group with RN for participation and observations.	
		3. After 2 hours repeat COWS. If score increased or adverse symptoms develop, call MD.	
		4. IF COWS is the same or less with no adverse symptoms, administer another 2-4 milligrams sublingually.	
		5. Repeat every 2 hours, if COWS same or patient still grading administer Suboxone 2-4 milligrams sublingually, up to total of 16 milligrams.	
		6. Patients may take additional 2-4 milligrams at bedtime or in a.m. on Day 2.	
		1. DAY 2: Patient returns at 0800 with prescription bottle and pills for count.	
		2. Assess with COWS. Administer 2-4 milligrams sublingually if patient did not take a.m. take home dose.	
		3. Calculate daily dose. (Day 1 + Night time dose - a.m. dose) Write prescription for one week.	
		MD Signature: _____ Date: _____	

## Sample Form

### Checklist for Bupenorphine Induction

All items must be completed and in client's chart before the client is induced.

1. Signed agreements for treatment with Subutex® /Suboxone®
2. Completed initial office visit examinations
3. Baseline drug screen
4. Completed and reviewed lab testing per order set
5. Completed level-of-care evaluation

## Suboxone Administration/Documentation Competency

The following competencies are required for nursing staff working within the MAT program at ARC. Determination of competencies may occur through observation, record reviews, clinical supervision, verbal recall of procedures, or post testing.

Nurse's Name \_\_\_\_\_ Date \_\_\_\_\_

Reviewer's Name \_\_\_\_\_

	Competency	Yes	No	ACTION
1	1 Provide patient with Suboxone literature, document on (Treatment Plan): a. Confirm patient understanding of risks and benefits b. Understands treatment alternatives for opiate dependence c. Understands typical side effects.			
2	a. Review patient history of most recent methadone use: b. Report any use in past 7 days to the physician.			
3	Administer Clinical Opiate Withdrawal Scale (COWS) and interpret scoring results. Baseline and every two hours thereafter x's 3 or per MD orders. a. Record response to dose b. Execute scheduled dosage, if no adverse response to test dose.			
4	Update Treatment Plan as patient moves through levels of care or any scheduled changes: a. Document confirmation of education on dose changes, b. Document confirm of education on goal changes (i.e., withdrawal to maintenance).			



## Online resources and reading

[www.niatx.net](http://www.niatx.net)

Information about medications approved for medication-assisted treatment

<http://www.alkermes.com>

<http://www.rb.com/home>

Acamprosate (Campral)

<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000272>

Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

<http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A72248>

Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005

<http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A82676>

Center for Substance Abuse Treatment. *Incorporating Alcohol Pharmacotherapies Into Medical Practice*. Treatment Improvement Protocol (TIP) Series 49. HHS Publication No. (SMA) 09-4380. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009

<http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A92752>

Center for Substance Abuse Treatment. Medical Assisted Treatment Communities Bulletin.

<http://www.csat.samhsa.gov/publications/Communities.aspx#2>

CSAT SAMHSA Buprenorphine Information Center

<http://buprenorphine.samhsa.gov/index.html>

Disulfiram (Antabuse®)

<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000726>

Methadone

<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000591>

Naltrexone (Vivitrol®)

<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000486>

National Council of State Legislatures “Medication Assisted Treatment for Opiate Addiction (MAT) Project”

<http://www.ncsl.org/default.aspx?tabid=14432>

NREPP: SAMHSA’s National Registry of Evidence-based Programs and Practices

<http://www.nrepp.samhsa.gov>

SAMHSA Medication-Assisted Treatment for Substance Use Disorders

<http://www.dpt.samhsa.gov/patients/mat.aspx>

## **Organizations providing buprenorphine training for physicians**

American Academy of Addiction Psychiatry (AAAP)

<http://www2.aaap.org>

American Osteopathic Academy of Addiction Medicine (AOAAM)

<http://www.aoaam.org>

American Psychiatric Association (APA)

<http://www.psych.org>

American Society of Addiction Medicine (ASAM)

<http://www.asam.org>

Physician Clinical Support System

<http://www.naabt.org/documents/PCSSPregnancy.pdf>

## **Additional Reading**

Baltimore Buprenorphine Initiative

<http://www.baltimorehealth.org/buprenorphine.html>

“Community Partnerships and Provider Training Increase Service Capacity and Access to Long-Term Treatment for Individuals With Heroin Addiction”

<http://www.innovations.ahrq.gov/content.aspx?id=1827>

"The Cost Effectiveness of Medication-Assisted Treatment for Opiate Addiction"  
<http://www.ncsl.org/IssuesResearch/Health/TheCostEffectivenessOfMATforOpiates/tabid/14134/Default.aspx>

"Developing Trends in Medication-Assisted Treatment for Opioid Dependence"  
<http://www.recoverytoday.net/Apr09/parrino.html>

"Erasing stigma toward medication-assisted treatment"  
<http://bit.ly/adD8qZ>

"New Drug Promises Shift in Treatment for Heroin Addicts"  
New York Times, August 11, 2003  
<http://nyti.ms/c4HIUs>

**Newsweek:** "What Addicts Need  
Addiction isn't a weakness; it's an illness. Now vaccines and other new drugs may change the way we treat it."  
<http://www.newsweek.com/id/114716>

"State policy influence on the early diffusion of buprenorphine in community treatment programs." Lori J Ducharme 1 and Amanda J Abraham 1  
*Subst Abuse Treat Prev Policy*. 2008; 3: 17.  
Published online 2008 June 20  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464589/>

"Treating Addiction as a Disease: The Promise of Medication-Assisted Recovery"  
Nora D. Volkow, M.D.  
Director, National Institute on Drug Abuse  
Testimony to Congress, June 23, 2010  
<http://www.nida.nih.gov/Testimony/6-23-10Testimony.html>

"Suboxone program working for some"  
<http://www.herald-dispatch.com/life/healthsource/x1816460377/Suboxone-program-working-for-some>

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