

## Addiction Messenger

### Part 2: Medication-Assisted Treatment - Helping Patients Succeed

**"The guiding vision of our work must be to create a city and a world in which people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated." ~ SAMHSA**

Stigma has been defined as 'a mark of disgrace or infamy' or 'a stain or reproach on one's reputation'. Individuals with addictions, by the time they need or seek treatment, are well aware of the sting of stigma. Those whose journey to recovery includes Medication Assisted Treatment (MAT) often continue – ironically – to be stigmatized – not just for having an addiction, but for the very tools they use to combat it.

"Stigma in MAT is real and cited by many individuals and professionals as the primary barrier to utilizing MAT."  
ATTC MAT Training (1: Module 3, Slide 5).

Part 2 of this three-part series will discuss practical ways behavioral health providers can support patients who utilize MAT, including strategies for helping them deal with stigma, and ideas for helping them manage and adhere to their medications. The series will continue to draw from and highlight the new ATTC on-line training on MAT (1).

### ***Understanding Stigma***

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Advancements in medicine are often met with hesitance, curiosity, and at times outright hostility, depending on social and political factors surrounding the disease or disorder. The use of MAT in substance abuse treatment is no exception, and in fact provokes a great deal of attention. The following section describes some current challenges and perspectives on MAT, and the associated stigma.

"There has been no consensus even within the recovering community about the role of 'medication-assisted recovery,'" concluded a panel of experts convened by the Betty Ford Institute (2):

"There appears to be essentially full agreement that formerly dependent individuals who are abstinent from all drugs of abuse but take, for example, insulin for diabetes or diuretics for hypertension, still meet contemporary views about being in recovery. There does not appear to be agreement regarding whether those whose use of alcohol has been blocked by

naltrexone, acamprosate, or disulfiram are also considered to be in recovery. Finally, it appears that only few of those presently in recovery within the United States consider individuals whose illicit opioid use is blocked by buprenorphine or methadone to be in recovery." (2)

These themes were also clearly reflected in statements made by participants of focus groups held in 2011 by regional Addiction Technology Transfer Centers, in prelude to creating the new MAT curriculum (1). Themes were consistent even though the groups were conducted across the U.S. with diverse individuals – including African-Americans, Asian and Pacific Islanders, Native-Americans, as well as Hispanic and Latino Americans – and professionals working in the field.

Comments reflected a general acceptance of medications used for the treatment of chronic medical conditions – excluding addiction and psychiatric issues. Results also point toward ambivalence regarding medications used for the treatment of alcohol, albeit with a growing understanding and acceptance for some addiction and psychiatric medications. Finally focus group participants also reported patients experiencing antagonism, especially for those using methadone as treatment for opioid dependency, but also related to the use of buprenorphine.

Antagonism was clear in blunt and dismissive statements about MAT that focus group members heard from legal and healthcare professionals, peers in recovery, and family members. One theme expressed across all focus groups was the difficulty of “coming out” to family members about their use of medications. Many participants talked about having a mutual understanding that it was not to be discussed, since any open conversation resulted in criticism and/or rejection.

Additionally, physicians were often less educated about the use of medications than patients expected, and some were even antagonistic or hostile. "I had one doctor tell me that he would rather see me on heroin than methadone," said a focus group member. Stigma from physicians not only has a negative impact on addictions treatment, but also in the larger context of healthcare, as these perspectives support the myths and misperceptions about addiction, and reduce access to MAT and support for recovery.

Stigma from judges, family members, doctors and social media about MAT also have serious implications and impede recovery. One professional reported that many of her clients felt that they held a “second class” recovery status; it was good but not quite “good enough”. Her concern was that this led to underutilization or premature

discontinuation of medications that could support recovery. This type of experience may also create a sense of shame for clients, and influence the entire recovery experience. In summary, stigma and misperceptions related to MAT limits treatment options and opportunities for health and healing.

## **MAT and Myth**

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A main concern echoing through many antagonistic comments reported by focus group members was about replacing one drug with another drug, thus undermining the true potential of recovery. It is a common myth about MAT, and a major area in which providers can help.

Meeting myth with facts and education can be effective in combating stigma; for example, by reinforcing the difference between medications and drugs, and physical dependence versus addiction (as discussed in Part 1). Providers can also share examples of other chronic illnesses (i.e. diabetes, heart disease) that are treated with maintenance medications. The more providers can learn about how medications work, and the research supporting their effectiveness (and the more they can help patients articulate this), the better they will be able to combat stigma and myth and support patient recovery. Patients can also be coached to talk to other professionals about what they have gone through with their addictions, and how MAT has helped them.

A related myth is that medications are not part of addiction treatment. Medications can and are an accepted and effective part of treatment of many chronic mental and physical conditions, and addictions medications work with bio-chemistry just as other medications do, and are vetted and approved by the FDA.

## **Peer-Support Groups**

Another pervasive myth is that the most common and accepted peer support groups – Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) – do not support the use of medications. Much of the objection from 12-step members is founded in a fear that members will use medications inappropriately and undermine their own recovery, as sometimes happens. Many members have also relapsed while using prescribed medication, and for many the safest path to sustained recovery becomes "just say no" to all medications. For others, the use of medications is necessary to support their sobriety.

Counselors can and should proactively prepare patients to address resistance by peer-support group members. One approach is to use

examples from peer-group program literature to underscore the importance of distinguishing the stance of a program from the opinions of its members. For instance, consider the following quotation from *The AA Member – Medications and Other Drugs*:

"Some alcohol dependent clients require medication: It becomes clear that just as it's wrong to enable or support any alcoholic to become re-addicted to any drug, it's equally wrong to deprive any alcoholic of medication which can alleviate or control other disabling physical and/or emotional problems." (3)

Importantly, the Big Book of AA, itself, says that the world is full of "fine doctors, psychologists, and practitioners of various kinds. Do not hesitate to take your health problems to such persons. Most of them give freely of themselves, that their fellows may enjoy sound minds and bodies.... *we should never belittle a good doctor or psychiatrist. Their services are often indispensable in treating a newcomer and in following his case afterward.*" [Chapter 9, p. 133]

The avenue to partnership with primary care is paved with acceptance and knowledge, just as the recovery communities acceptance of MAT was also paved long ago. However, despite the overall support of AA and NA for MAT, some written material – such as a 1996 NA bulletin about methadone (<http://www.na.org/?ID=bulletins-bull29>) – seems to indicate that people who are taking methadone and attend NA meetings should not speak and cannot lead meetings. Some NA groups are even hostile to individuals who are receiving methadone as part of their course of treatment. Here, providers and peer recovery coaches and sponsors can assist by being prepared to identify the most accepting and appropriate support groups and sponsors.

### **MAT and Discrimination**

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Providers can also help patients using MAT to address discrimination, particularly in regard to use of addictions medications for opioid treatment. Per SAMHSA: "This discrimination is largely due to lack of knowledge about MAT's value, effectiveness, and safety; and a lack of knowledge about the anti-discrimination laws that protect people who are using MAT. Discrimination is also common because people in MAT frequently do not have the tools necessary to educate employers, landlords, courts, and others about MAT and relevant legal protections." (4)

Providers can share accurate information and resources with patients. An example is a free publication by SAMHSA (4), which covers issues and

laws related to housing; government benefits and services, and private educational, health care, and other facilities. The publication aims to reduce discrimination by giving patients and advocates basic information necessary to exercise their rights; or, at a minimum, to know where to find help. It also aims to educate those who might discriminate about both the laws and MAT, itself.

The Legal Action Committee ([www.lac.org](http://www.lac.org)) is another reliable source for useful publications, including one covering the legal rights related to child welfare and/or the criminal justice system (5).

## **Medication Support**

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If the patient is equipped with comprehensive information regarding the importance of taking their medications regularly, avoiding potential interactions, keeping to a schedule, etc., he/she will experience a greater sense of control, and will know what to expect. Also, as described in the ATTC Network MAT training, supporting patients in continuing to take prescribed medications properly can significantly improve treatment outcomes, as well as treatment for other co-morbid medical conditions, such as HIV or hepatitis C, or hypertension OR psychiatric conditions such as bipolar disorder, or anxiety (1: Module 2, Slide 86).

There are several strategies providers can employ regarding medication management and adherence, and these can be effective whether the medication is designed to treat a mental health, medical, or substance use disorders. When discussing medications it is important to keep in mind that medical decisions must be made by trained and licensed providers, and although substance abuse treatment providers cannot make specific recommendations, they can encourage patients to talk to their prescribing provider and they can support the patients use of MAT as one tool in their recovery process.

## **Talking About Medications**

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For patients using MAT, behavioral health providers should plan to devote about five to ten minutes every few counseling sessions to discuss medication usage and the importance of following their treatment plan. These open discussions help patients experience conversations about adherence as routine, and it builds rapport by demonstrating support for the physical, mental, and emotional well being of patients.

An important initial step is the development of a game plan for how to regularly introduce the topic of medication use. You might begin a discussion by reminding patients that taking medications as prescribed

can help prevent relapse, and that the more informed a patient can be about their medications the greater chance they will follow their treatment plan. Or, as part of "normalizing" the discussion, patients should be encouraged to talk about their use of medications for any chronic condition, such as high blood pressure or insulin for type 2 diabetes.

### **Overall Communication Tips**

There are three overarching communication tips to keep in mind whenever a discussion about medications occurs. First, be prepared to provide patients with information regarding potential medication interactions – such as interactions with food, alcohol or other drugs, other medications, and/or pregnancy considerations. Second, be aware that some medications may require a routine blood test to monitor for side effects like liver toxicity or blood pressure; while this is something a physician would initiate and monitor, it is a process you can collaboratively support. Lastly, be prepared to discuss the positive outcomes related to consistent medication compliance as well as potential side effects from the medications themselves.

### **Medication Adherence**

Several specific prompts or questions are important to can keep in mind when discussing medication adherence with patients:

- How many doses have you missed?
- Have you **felt or acted different** on days when you missed your medication?
- Was missing a scheduled dose of medication related to any **substance use relapse?**
- Why did you miss the medication? Did you forget, or did you choose not to take it at that time?

Leading into a discussion about adherence, providers might ask how many doses patients missed during a specified time period, rather than asking if they missed doses. This implies acceptance that missing doses is a real possibility and may prompt a more open discussion. This open communication between provider and patient generates a chance to assess potential patterns of non-compliance, or to assess specific circumstances that may contribute to missed doses. It is possible that missed doses may be a sign of future substance use relapse, which would be critical information to learn. It's important to refrain from asking questions about adherence in a judgmental or confrontational way. Body language may also influence the message and communication while interacting with your patients on this potentially sensitive topic.

The purpose of this type of discussion is to help your patients stay on a path that will hopefully lead to better overall health.

### **Medication Adherence: Common Reasons for Missing Doses**

Patients may cite a myriad of reasons for why they miss medication doses, whether frequently or sporadically, and this always presents an opportunity to acknowledge that many people miss taking their medication at times. Then, once a patient provides a specific reason for missing a dose (or doses), it is critical to help them identify one or more concrete strategies to lessen barriers to ongoing medication adherence. Additionally, you might need to consult with the prescriber, informing them about the frequency of missed doses and asking about related medical consequences. The prescriber may also be involved in developing strategies for medication adherence.

The following are a few of the more common reasons given for missing doses, and suggestions for how to respond (1):

***“I don’t need to take medications anymore, because I am cured.”***

Sometimes, when patients first start taking medications, they feel better than they have in a long time, and consider themselves to be suddenly healed or cured. Because of this, they may be inclined to cease the use of medications or taper the prescribed dose. It may be important to remind patients that for many medications, they need to take the medications everyday at the prescribed dose so that a therapeutic level builds in the body.

***“I don’t like the side effects.”***

All types of medications, including those approved for treating chronic medical conditions, psychiatric conditions, and those used in the treatment of alcohol or opioid addiction, have at least some negative side effects. It is likely the case, however, that the minor side effects experienced when taking prescribed medications under a physician's supervision are much less severe than the negative effects associated with harmful use of alcohol and illicit drugs, or the misuse or abuse of prescription medications. Behavioral health providers can help the client bring the side effects back to their doctor, as many of these can be managed through dose adjustments, supportive medications, or just a better understanding that the effects will diminish with time.

***“I don’t want to hear objections or ridicule from friends and family members.”***

As discussed previously, a pervasive myth is the notion that individuals who are taking a medication for their opioid or alcohol addiction (and, to a lesser extent, a medication for a psychiatric condition) are not in recovery, and that they are replacing one drug for another. Again, it is critical to help arm patients with information about the physiology and biochemistry of addiction to combat this stigma. Friends or family members who ridicule a patient receiving MAT may also be in need of education or information, including how MAT works and evidence supporting its effectiveness as a treatment tool.

The ATTC MAT curriculum (1) includes other common reasons given for missing doses, along with strategies for discussing them and ideas for helping patients avoid missed doses in the first place (e.g., using an alarm, a pill box, and/or placing medications near commonly used objects); it also covers crucial information about responding to patients who admit to purposefully deciding not to take doses (1: Module 2, Slides 86-108).

### **Mat in the Context of Recovery**

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It is critical that individuals are able to access and be supported in using the tools that are relevant to their recovery, whether they utilize a medication, a form of unforced outpatient treatment, support from a recovering peer group, or some alternative lifestyle. The tools that individuals, families and communities use are just that – tools; they do not define or undermine the quality of this recovery.

As more medications become available for the treatment of addiction, how can individuals, family, community, and the healthcare profession begin to define and understand MAT in the context of recovery? Additionally, how can the definition of recovery be understood and be inclusive of medications as a legitimate and effective tool for pursuing recovery?

These questions were considered in *National Summit on Recovery Conference*, convened by the Substance Abuse and Mental Health Services Administration in 2005. The report it generated (7) articulated a number of principles key to understanding recovery, including the role medications can play as a supportive tool. For example, the report's first principle states that recovery has many pathways, and the report emphasizes the need to transcend shame and stigma and to define and evaluate recovery by its "condition", not the method by which one attains it. In this context, recovery is defined as "a process of change through

which individuals work to improve their own health and well-being, live a self-directed life, and strive to achieve their full potential."

There is also an emerging national consensus supporting recovery as a non-linear process, a chronic condition that may involve relapse and other setbacks, but is based on continual growth and improved functioning (2,6,7). Of relevance is whether a person in the process of building or rebuilding what they have lost, or never had, due to their condition and its consequences. Are their relationships and quality of their life improving? Are they obtaining education, employment, housing, and/or increasingly become involved in constructive roles in the community? Evaluating recovery in this context – rather than judging the journey's tools – makes much more sense.

## **Conclusion**

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Clearly, there are numerous, specific strategies clinicians can employ to help patients succeed when using MAT and, ultimately, in their overall treatment and recovery approaches. Acquiring and sharing accurate information and facts that run counter to stigmatizing myths is key, as is supporting medication management and adherence.

Another crucial area is communicating and collaborating with physicians, as we'll discuss in Part 3, along with issues related to increasing and improving access for patients to MAT.

For more information, please consider exploring the resources listed below, or contact your regional ATTC: [www.attcnetwork.org](http://www.attcnetwork.org).

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## **Sources/Resources**

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- 1. Medication Assisted Treatment for Special Populations (2012).** Addiction Technology Transfer Center (on-line course); Center for Substance Abuse Treatment, Substance Abuse and Mental Health Administration (SAMHSA). <http://www.attcelearn.org/>.
- 2. The Betty Ford Institute Consensus Panel.** Journal of Substance Abuse Treatment 33 (2007) 221–228.  
[http://www.facesandvoicesofrecovery.org/pdf/Betty\\_Ford\\_Institute\\_Consensus\\_Panel.pdf](http://www.facesandvoicesofrecovery.org/pdf/Betty_Ford_Institute_Consensus_Panel.pdf)
- 3. The AA Member – Medications and Other Drugs (2001).**  
<http://www.aa.org/catalog.cfm?origpage=189&product=33>
- 4. Rights for Individuals on Medication-Assisted Treatment.** Substance Abuse and Mental Health Services Administration (2009).  
<http://store.samhsa.gov/product/Rights-for-Individuals-on-Medication-Assisted-Treatment/SMA09-4449>
- 5. Educating Courts, Other Government Agencies and Employers About Methadone.** Legal Action Center, 2009.  
[http://www.lac.org/index.php/lac/alcohol\\_drug\\_publications#mat](http://www.lac.org/index.php/lac/alcohol_drug_publications#mat)
- 6. National Summit on Recovery Conference** (report), Substance Abuse and Mental Health Services Administration (2005).  
[http://pfr.samhsa.gov/docs/ROSCs\\_principles\\_elements\\_handout.pdf](http://pfr.samhsa.gov/docs/ROSCs_principles_elements_handout.pdf)  
(retrieved 08.19.2011).
- 7. Recovery-oriented Methadone Maintenance.** White WL & Torres L Lisa-Mojer Torres (2010). Published by the Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center.  
[http://www.attcnetwork.org/userfiles/file/GreatLakes/5th%20Monograph\\_RM\\_Methadone.pdf](http://www.attcnetwork.org/userfiles/file/GreatLakes/5th%20Monograph_RM_Methadone.pdf)