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Counterarguments from the Grayken Center for Addiction re: "AATOD MAT Act Fact Sheet"

Misleading AATOD statement	Corrections
It's true that buprenorphine, in combination with psychosocial services, has been effectively used for two decades. However, the vast majority of individuals currently receive no counseling. This has led to lower treatment retention and poor clinical outcomes. Simply prescribing medication alone is not medication assisted treatment.	Medication for opioid use disorder (MOUD) alone, i.e. without counseling, has been an effective approach for many. In fact, a randomized study of patients receiving buprenorphine observed no difference between patients receiving physician medication management and physician medication management plus cognitive-behavioral therapy: both groups showed similar reductions in self-reported frequency of illicit opioid use.[1] While it is important to acknowledge the benefits of counseling and increased psychosocial support, treatment with medication alone can have equally beneficial outcomes and delaying initiation of MOUD puts individuals at an unnecessary risk of overdose. Additionally, the required waiver training does nothing to ensure that patients will be offered or receive counseling or other forms of psychosocial care for opioid use disorder.
In response to the opioid crisis, federal and state authorities worked urgently to implement prescribing limits and increase prescriber education to mitigate the misguided prescribing practices that contributed to the epidemic. This legislation moves in the opposite direction by removing the education requirements and limits that currently protect consumers and making it easier to prescribe a medication known to be highly diverted and misused.	The MAT Act does remove the current training requirements (widely considered to be ineffective), but it does direct SAMHSA to launch a national educational campaign connecting providers to publicly available training resources on best practices.
Eliminating the waiver will massively expand access to *medication*, not *treatment*. This legislation does not provide medical professionals with the resources needed to integrate quality substance use disorder treatment into their settings. Many individuals with an opioid use disorder engage in polysubstance misuse, much of which requires psychosocial interventions, not medication alone. Of adults with a substance use disorder, 37.9% also have a co-occurring mental health disorder.	Psychosocial interventions are to be encouraged and supported. However, in 2017 more than half (56.3%) of all rural counties lacked a single physician with a waiver to prescribe buprenorphine.[2] Medication and psychosocial interventions are key components of quality treatment. It is difficult to imagine quality treatment for other conditions like diabetes if access to medications were so limited. Why do we accept such limited access for addiction?

There are no data on the efficacy or quality of MAT provided in primary care settings. There is, however, data available on the rates of buprenorphine misuse. The RADARS® (Researched Abuse Diversion Addiction Related) surveillance system found that during 2018, individuals presenting for opioid treatment in the U.S. reported misuse of buprenorphine in 27.4% of cases and within these, 15.3% indicated misuse of buprenorphine by injection (unpublished data on file).	Buprenorphine safeguards against opioid overdose and helps keep individuals alive, even if they are "misusing" the medication. Furthermore, we know that antibiotics and allergy medications have higher rates of non-prescribed use than does buprenorphine. Buprenorphine is a far safer prescription medication than are many other medications that do not have an additional special educational requirement. Examples include insulin, chemotherapy agents, fentanyl, and Oxycontin.
The stigma surrounding MAT for opioid use disorder is generated in large part when diversion and misuse of these medications occur. Diversion control plans are not required of MAT provided in a primary care setting. The rate of buprenorphine diversion has been steadily increasing as more buprenorphine is prescribed. The number of opioid treatment admissions reporting buprenorphine as a primary drug of MISUSE has also steadily increased.	Misuse and diversion do not justify provider or societal stigma. Furthermore, diversion of buprenorphine is more commonly undertaken to self-medicate withdrawal symptoms than to achieve a pleasurable high.[3–6]
The requirement to obtain a license has already proven insufficient to ensure safe prescribing practices. A lack of adequate prescriber training on best practice guidelines for pain management and opioid prescribing has been identified as a significant factor in the development of the opioid epidemic. The waiver requirement addresses these past wrongs and helps protect consumers from untrained practitioners inappropriately prescribing powerful opioid medications.	Continuing to impose the waiver requirement on prescribers of buprenorphine has a stigmatizing effect and serves as a barrier that is often cited by medical providers as the reason that they do not choose to prescribe this medication. The federal government has already determined that special education should not be required in order for a medical provider to prescribe buprenorphine for up to 30 simultaneous patients; and it is illogical to claim that the education is needed in order to prescribe for patients 31-275, but not for patients 1-30. A more appropriate requirement would be for all medical providers who obtain a license to prescribe controlled substances to complete a short course on the risk of substance use disorder (SUD) and the basics of SUD treatment.

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