American Association for the Treatment of Opioid Dependence, Inc.

The Mainstreaming Addiction Treatment (MAT) Act: Fact-Checking the "Fact" Sheet

Don't make important policy decisions without good data. Examine what is happening in our own country before eliminating training and oversight.

Vote NO on H.R. 2482 and S. 2074

The MAT Act "Fact" Sheet	✓ FACT CHECK
"For two decades, **buprenorphine** has been used as a safe, effective and life-saving **medication-assisted treatment (MAT)** for individuals suffering from a substance use disorder."	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.[1,2] **Simply prescribing medication alone is not MAT.**
"Medical professionals need a **special DEA waiver** to prescribe buprenorphine to treat substance use disorder, which leads to treatment bottlenecks and a lack of providers."	No such bottleneck exists. SAMHSA approves applicants within 45 days. **There are currently more than 72,000 waivered prescribers approved to treat 4.3 million patients.**[3] This is more than double the number of estimated individuals living with an opioid use disorder in our country. However, only about half of the waivered medical practitioners are actually prescribing.[4]
"This outdated waiver requirement has stuck around even though **medical professionals can prescribe the same drug for pain** without jumping through bureaucratic hoops."	Federal and state authorities have been working urgently to implement prescribing limits and increase prescriber education to mitigate the practices that led to the current opioid epidemic. **This legislation moves in the opposite direction by removing education requirements and limits**, making it easier to prescribe a medication known to be highly diverted and misused.
"Removing this barrier will **massively expand treatment access**, making it easier for medical professionals to integrate substance use disorder treatment into primary care settings."	Eliminating the waiver and training requirements 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. Only 8% of American medical schools offer education on addiction.[5] Yet **this legislation will *reduce* education for medical professionals wishing to treat this disorder.**
"After nearly **20 years of safe treatment**, there is no good reason to maintain a separate, more burdensome regulatory regime restricting access to safe, proven addiction treatments including buprenorphine."	**There is no data on the efficacy or quality of MAT provided in primary care settings**. There is, however, data available on the rates of misuse and risks of overdose associated with buprenorphine.[6] The RADARS® (Researched Abuse Diversion Addiction Related) surveillance system reported past month prevalence in the U.S. of **INTRAVENOUS BUPRENORPHINE misuse of 45.5%** by individuals presenting for opioid treatment.[7]

[1] T McLellan, A & O. Arndt, Isabelle & Metzger, David & Woody, George & O'Brien, Charles. (1993). The Effects of Psychosocial Services in Substance-Abuse Treatment. JAMA: the journal of the American Medical Association. 269. 1953-9. 10.3109/10884609309149701

[2] Principles of Effective Treatment, A Research Based Guide (3rd Edition), National Institute on Drug Abuse, last update January 2018

[3] Practitioner and Program Data, SAMHSA, https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/practitioner-program-data

[4] The SAMHSA Evaluation of the Impact of the DATA Waiver Program, Summary Report, March 30, 2006

[5] Hoffman, Jane. "Most Doctors are Ill-Equipped to Deal with the Opioid Epidemic: Few Medical Schools Teach Addiction." *New York Times (New York)* 10, September, 2018.

[6] Lofwall, M.R, Walsh, S. L. 2014. A review of buprenorphine diversion and misuse: the current evidence base and experiences from around the world. *Journal of Addiction Medicine.* Sep-Oct;8(5):315-26.

[7] Dart RC. 5th Annual Scientifica Meeting Presentation. Evaluation of ADFs using RADARS system data. 2011 http://www.radars.org/Home2/AnnualMeeting/RADARSSystem2011AnnualMeeting.aspx

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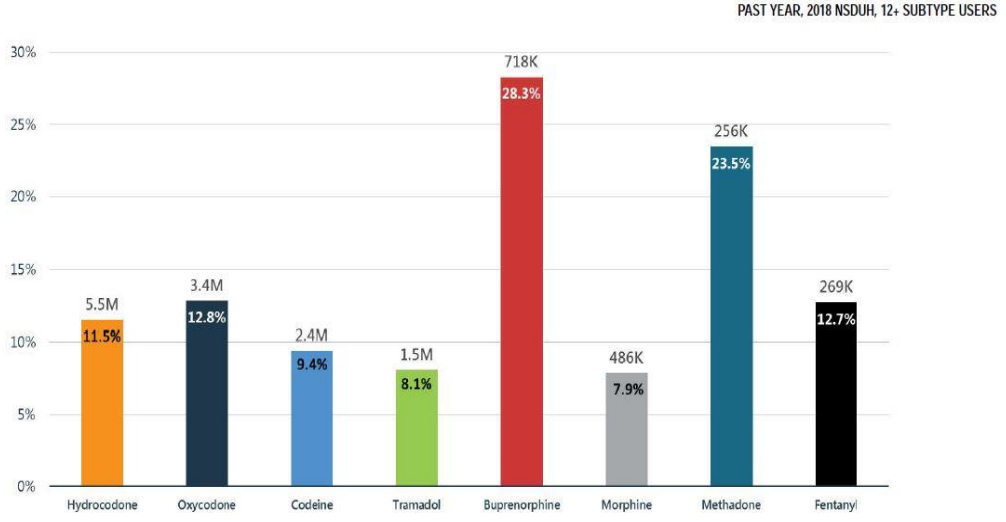
"The additional wavier requirement reflects a **longstanding stigma** around substance use treatment and sends a message to the medical community that they lack the knowledge or ability to effectively treat a patient with substance use disorder."	The stigma surrounding MAT for opioid use disorder is 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.[8] **The number of opioid treatment admissions reporting buprenorphine as a primary drug of MISUSE has also *steadily increased*.** [6]
"Practitioners are **already required to obtain a license** to prescribe controlled substances and meet any state-level requirements to prescribe buprenorphine."	The requirement to obtain a license has **already proven insufficient to ensure safe prescribing practices.** A prior lack of adequate training and best practice guidelines for pain management and opioid prescribing led to inadvertently bad prescribing outcomes and deaths. **Practitioners are not trained to use opioid treatment medications.** The waiver requirement helps protect consumers from untrained practitioners inappropriately prescribing powerful opioids.
"After **France took similar action** to make buprenorphine available without a specialized waiver, opioid overdose deaths declined by 79 percent over a four-year period."	This legislation fails to address key differences between France and the model that would be created in the U.S. as a result of this legislation. **In France, practitioners can only prescribe for seven days at a time and must specifically justify a longer duration.** No such limits exist in the U.S. where schedule III drugs like buprenorphine can be refilled up to 5 times without requiring a new prescription. Pharmacies in France supervise administration for the induction period and for some time beyond. U.S. pharmacies are not equipped to oversee daily administration of medication to patients. Also, widespread co-prescribing of benzodiazepines in France suggests a need for more practitioner training: *"**further efforts to improve the safety of buprenorphine are warranted**, and potential means for achieving this goal in France include **increased control of buprenorphine prescriptions**, **physician training** on the risks of excessive dosing and co-prescription of other psychotropics with buprenorphine (especially benzodiazepines)"*[9] Exactly what this legislation would remove.

Misuse of Pain Reliever Subtypes in Past Year among Persons Aged 12 and Up[10]



[8] Treatment Center Programs Combined, 2008-2018, RADARS® (Researched Abuse Diversion Addiction Related)

[9] Auriacombe M, Fatseas M, Dubernet J, et al. French field experience with buprenorphine. American Journal on Addictions. 2004;13:S17–28

[10] The National Survey on Drug Use and Health: 2018, SAMHSA