**HEROIN ACTION COALITION INTERVIEW QUESTIONS:**

**On Medically Assisted Treatment (MAT), Methadone Maintenance (MM),**

**& Long-Term Abstinence-Based Residential Treatment (ABRT)**

* 1) There is a difference between MAT patients who are using MM as a harm reduction method to taper slowly off of illicit opioids, and those individuals enrolled in OTPs who are using methadone to maintain and enhance their drug use. Research shows that about 28% – 33% of MM patients **do not use** other illicit drugs while in treatment (Flynn, et al. 2003; Cohen, et al., 2005). One can therefore deduce that 67% – 72% of MM patients **DO USE** other illicit drugs while in treatment. For the parents of kids who are in “treatment” and still injecting heroin, ingesting benzos, or chugging fifths of Vodka every night (as many parents have witnessed), they do not consider this “treatment” to be effective. To them, there is no difference between their adult child’s deadly substance use disorder while not in a treatment program, and their adult child’s deadly substance use disorder while prescribed methadone in a treatment program –except that they may not have to steal in order to stave off withdrawal. While reducing criminal activity may be a goal of the state, it is not the ultimate goal of the parent, nor should it be the ultimate goal of a conscientious society. From the perspective of these parents, their child is now able to obtain a steady supply of drugs from a different, albeit legitimate, dealer. Some parents justifiably conclude that their child’s free and steady drug supply, now “enables” him to remain high –particularly in OTPs which allow the participant to increase their dosage by 5 mg every three days and request more from the doc whenever they reach a mg.-specific platform. Additionally, parents who listen to their kids refer to their “free drugs” –paid for by insurance or Medicaid, while sitting around with friends at their parent’s kitchen table are understandably appalled. Advocates are told that this scenario cannot possibly be occurring because these kids are drug tested. Obviously, when a large population of young people with lived experience in OTPs, and their parents, report this experience –not only is it “possible” that it’s occurring –it is a serious problem and one that needs to be addressed. How will this problem be resolved?
* 2) Parents tell us they are concerned that there is no accountability for their kids who are still using illicit and dangerous substances “while in treatment”.The droves of drug-seeking kids still “using” while in “treatment” has given MAT (particularly MM) a ‘bad name’ –despite the fact that it has worked exceptionally well for the approximate third who are successfully using it as a harm reduction strategy and tapering off over time. OTP clients report their ability to purchase drugs up and down the methadone line –particularly Clonidines and Phenergans –which purportedly interact with methadone to get the user “high”, but are not caught during drug tests. This is not so much a problem with Methadone Maintenance, as much as it is a failure of MM providers to resolve the drug-seeking and using problem with some of their clients, and a failure of DHMH to hold them accountable for doing so. What should MAT treatment providers be doing to ensure that their patients are NOT using other illicit drugs while “in treatment”? What should DHMH be doing to ensure that providers are complying with these strategies?
* 3) Research shows that suicidal ideation is particularly high among MM patients (Hubbard, et al. 1997; Best, et al, 2009). Parents and MAT enrollees report that they get little if any substantive mental health or individual treatment while enrolled in many OTPs. Some parents are understandably distraught when their child returns home after a 30-day rehab stint on a MAT prescription and is so chronically depressed that he or she can barely leave their room for months –much less find a job, return to school, or show any indication that they will ever function normally again. Parents who were at first relieved that their child was recovering from a Substance Use Disorder, now witness their child suffering from deep and chronic depression and anxiety, indicative of opiate use (legal or illicit), which did not dissipate, as expected, after they stopped “getting high”. This problem is intensified if they never receive any mental health counseling in their MAT program. How would you respond to these parents? Is there anything that MAT providers could or should be doing to lower this extremely high rate of dangerous symptomatic side effects associated with opiate maintenance? What role should DHMH play in addressing this issue?
* 4) MM has been linked to impaired cognitive function in a 2013 systematic review of **35 published scientific studies** (Wang, et al., 2013). MM has been linked to neuropsychological deficits (Davis, et al., 2002; Mintzer, et al., 2004). MM has been linked to slower cognitive processing speeds, lower visual-spatial attention spans and lower cognitive flexibility, as well as less accuracy on working memory and analogical reasoning than ABRT (Verdejo, et al., 2005). MM has been linked to lower scores on emotion perception and social inference than ABRT (McDonald, et al., 2012). This often translates into the young person’s inability to gain full-time employment –a trend that correlates with MM patients (Hubbard, et al. 1997). Many Parents, MAT patients and former MM enrollees report trouble with basic functioning –particularly in areas managed by the frontal cortex –prioritizing, remembering, organizing, coping, etc. Many parents are distressed to find that even after their son or daughter has stopped using illicit opiates and is being treated on maintenance opioids –it is tragically difficult for them to figure out how to perform basic life skills –obtain food, budget money, make and keep appointments, get a job, etc. Both the data, as well as anecdotal evidence, indicate that the brain may heal itself to the point where it is capable of functioning on par with brains that have never been on opiates after two years of abstinence. Young people with lived experience talk about the “fog” that doesn’t begin to lift for many months after abstaining from opiates –and that isn’t fully gone for about two years. Parents are concerned that they may be raising young adults (who are still dependent on them) who cannot figure out how to live successfully and independently. It is very common for parents whose kids are maintained on opiates to notice the same “cognitive deficits” reported consistently throughout the data. Their hope is that their child’s brain will return to what it once was, prior to the introduction of opiates. Despite data that seems to show that two years of abstinence seems to be the key to achieving this goal, teens (18 – 19) and young adults are often told that they need to remain on MM for 5 or more years and sometimes for the rest of their life. This response to a young person whose brain is still maturing seems to contradict the data?
* 5)MM has been linked to suppressed testosterone levels associated with erectile dysfunction, fatigue, and mood disturbances (McMaster University, 2014). Boys report that they have trouble performing sexually when they are using –and this problem persists when they are on opiate maintenance (methadone in particular). In fact, the street term “dope dick” is frequently used to refer to the issue. This is a huge big deal for young adult males. Some are not aware that it is caused by their continued opiate use, particularly if the methadone clinic fails to tell them –and they think that there is something permanently wrong with them –that they are damaged for life. This is highly stressful for them and thus for their parents as well. How would you respond to this data? Do you feel that the addiction field in general needs to be more forthcoming about presenting ALL treatment options and the related side effects?
* 6) It is not uncommon for young transition age adults to be referred to methadone clinics without an explanation of options. Once they are enrolled for a short period and find it is not working for them due to any number of factors –inability to get to the provider every day, IOP or PHP (if offered) interferes with a job, perception that they are still addicted –they discover they are trapped in this treatment modality and are unable to switch to ABRT. This is due to the fact that methadone withdrawal is one of the most brutally painful and long-lasting of any other opiate, and so detox facilities will not accept MM clients who are taking more than 30 mg/day, because insurance will not pay for the prolonged detox phase. The young patient may feel justifiably outraged to discover that they no longer have the option to CHOOSE ABRT, and that they were never given that choice in the first place. For them, MM has come to be known as “liquid prison”. Kids in this situation have been known to wean themselves off the methadone with heroin or any other illicitly obtained opiate, and then enter a detox program after the methadone is sufficiently out of their system. In this way, they use heroin as a “harm reduction strategy” for their unwanted methadone dependence. Their families feel that our treatment system should preserve choice and provide treatment based on medical necessity, rather than on insurance criteria. Advocates are told that OTPs must wean clients off methadone if they request it. However, numerous complaints of OTPs refusing (unless the reason is linked to the client’s inability to pay) are frequent –and there is no authority to complain to enforce client rights. Are there any medically-driven criteria that would explain why an individual is able to detox off ALL opiates, other than methadone, in a residential detox facility? Do you feel that this is a failure of DHMH to mandate medically-driven standards for entry to treatment and enforce them, as opposed to allowing insurance-driven standards to prevail?
* 7) Parents gauge recovery on more than just their child’s drug use. Best-Practice treatment suggests that an individual with a Substance Use Disorder (SUD) is not healed until they are leading a “normal” life –stable housing, job or school, positive family relationships, stable mental and emotional health, etc. Therefore, a treatment program should either provide support services designed to attain these outcome measures or link them to outside providers who provide these services. Some methadone clinics are notorious for dosing clients every morning and never providing even an hour of counseling or therapy, ever. Parents who were expecting to see progress toward self-sustaining independent living are dismayed to find that even though their child is now receiving “treatment”, they are not receiving even the most minimal assistance with recovering their “lost lives”. In fact, the only thing that has changed is that their child is receiving a “new drug” in place of the “old drug”. Hence, the perceptions that MAT simply “exchanges one drug for another” and replaces one drug dealer with another (the clinic is viewed as the new “for-profit” dealer). This scenario obviously tarnishes the reputations of reputable MAT prescribers who are providing very valuable and beneficial therapy to their clients and linking them to services appropriate to their needs. What would you say to these parents? How can this gap in the continuum of care for recovery services best be addressed? What should the role of DHMH be in ensuring that our kids get the assistance they need to get back on their feet after suffering for years with a grave and debilitating mental health disorder –SUD, which robbed them of their capacity to develop normally and progress alongside their same-age peers?
* 8) Where are the peers with lived experience on this panel who have not succeeded with MAT? Don’t we need their input as well as the input from the peers who benefitted from MAT?
* 9) What do you think about the following statement: In essence, advocates are not AGAINST the use of methadone or Suboxone as a treatment option. They are against:
* MAT providers who either fail to drug test or who continue to provide clients with their dose of methadone or their Suboxone prescription even when they are using other dangerous illicit drugs;
* MAT providers and policy makers are not honest or transparent about the side effects associated with MAT;
* MAT providers who do not address mental health issues, particularly those which are known to be associated with opiate maintenance, such as depression, anxiety and suicide;
* MAT providers who give no indication that they ever plan to taper their patient off of opiates and teens and young adults are prescribed ever-increasing doses;
* MAT providers who do not provide effective case management –failing to assess the client’s full array of needs and provide referrals to appropriate services;
* MAT providers who fail to warn their clients that they will not be able to switch to an opiate detox / ABRT path to recovery if they choose MAT, as well as the reasons why;
* MAT providers who spend approximately six minutes per day with a client and call this “treatment”;
* Detox providers who are insistent that they know what’s best for their clients, regardless of the client’s own experiences and history, and insist that their client resumes MAT, after a prolonged and mostly successful period of abstinence;
* Policy makers who undermine the recovery of ABRT patients by pressuring ABRT programs to accept MAT patients because that seems like an easier solution than to create enough halfway house programs to support BOTH paths to recovery equally;
* Health Department staff that steer patients into their own county-funded programs, regardless of whether it is the “best fit” for a patient, and without providing information about all of the available **statewide** options for which the patient may be eligible.

**CONCLUSION:** Any discussion that fails to address these very real issues will continue to alienate many parents and peers by invalidating their perceptions and ignoring their concerns. This is not a debate about whether methadone or ABRT is the most effective. Both have been proven to be life-saving options for so many people. It is a battle to maintain informed choice, to hold treatment providers accountable for providing effective outcomes, and to motivate policy makers to create an open, honest, transparent, and collaborative system of care that works for its consumers.