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# Counselors Seek Balance in Discussing MAT with Patients

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Sharing a table during a professional conference a few years ago, the clinical director of a Denver-area outpatient addiction treatment agency was reminded how physicians and substance use counselors can find themselves worlds apart in their thinking.

A doctor was discussing having seen a patient who informed him he had run out of his Adderall, Joyce Smith recalls. The dialogue then went something like this:

*Smith: Did you run a urine screen?*

*Doctor: No. My patients always tell me the truth.*

Fortunately, Smith tells *Addiction Professional*, these kinds of conversations don't play out at Creative Treatment Options, the organization where she oversees clinical care. The agency, which has been in operation for more than two decades, is seeing an enviable level of cooperation between physicians and non-MD clinicians as they work to improve outcomes for patients, many of whom are court-ordered to treatment. At two of its substance use treatment locations, Creative Treatment Options administers on-site injectable naltrexone for opioid use disorder and prescribes buprenorphine-naloxone (Suboxone) for OUD and disulfiram (Antabuse) for alcohol use disorder.

“It is a nice collaborative relationship that we have,” Smith explains. “The people providing the meds know their limits, and the counselors know theirs.”

The agency didn't discover some secret sauce to make this happen. Success grew from hard experience.

“We tried this in a couple of other places, and it was a disaster,” Smith says. One physician with whom the agency tried to work didn't hesitate to prescribe the potentially dangerous combination of buprenorphine with the benzodiazepine Xanax. That prescriber also believed that one monthly group counseling session sufficed for patient support beyond the medication.

“We don't assume here that everyone needs a medication forever,” Smith says. “The physicians we work with support that.”

**Counselors driving the process**

Front-line clinicians in treatment centers often can have a more profound role in establishing organizational culture around medication-assisted treatment (MAT) than the physicians who prescribe the medications. They work at the center of conversations where both patient and counselor might share personal views on medication that could shape the treatment plan.

“Counselors will tell me that some patients come in and say, 'All I want is medication—it saved my life,'” says Diane Sevening, president of NAADAC, The Association for Addiction Professionals and assistant professor at the University of South Dakota School of Health Sciences. The overdose reversal drug naloxone gave these patients a chance at recovery, and they now see medication as their cure-all.

From the counselor's perspective, however, that mindset doesn't position the patient for healthy outcomes in the long term. Educators such as Sevening emphasize MAT as one tool in the toolbox. It is an essential tool for many, especially with fentanyl's infiltration into the illicit drug supply, but not enough in itself to address the underlying issues that can fuel a recurrence to harmful substance use.

“The medication alone is not going to help you with a lot of the other things going on in your life,” Sevening tells *Addiction Professional*.

A counselor often becomes the first line of communication for a patient considering medication treatment, and of course will bring his/her own personal views about medication's value to the discussion. Cynthia Moreno Tuohy, NAADAC's executive director, tells *Addiction Professional* that she believes the stereotypical “do it like I did it” perspective of the counselor whose recovery did not include medication is now widely considered “old school.”

“A lot [of counselors] have adjusted their attitude.” Tuohy says.

Training related to medication treatments, both the most commonly used and other promising interventions, has become commonplace within NAADAC's education agenda. Tuohy believes it is important for counselors to stay current on any developments in medication treatment. Much of the training focuses on strategies for successfully integrating medication with clinical strategies embracing principles such as Stages of Change theory.

“I think counselors are the best resource to clients,” Tuohy says. Conversations about the role of medications in treating a biologically based illness can help to reduce client self-blame. “If you don't bring it up, it's not likely to come up,” she says.

In many treatment organizations, the perspectives of executive staff and line clinicians each will have a role in defining the degree to which the organization embraces MAT and how it communicates with patients on the use of medications. Sevening believes counselors have the greatest potential influence in stand-alone centers that are not dictated by the practices of major corporate ownership.

**Ominous trend**

At the same time that leaders in counseling have helped many of their colleagues to shed longstanding biases against medication, they warn that the "medication first" approach to treatment that has been driven by the gravity of the opioid crisis is being redefined by some in the medical community as "medication only."

Mita Johnson, who chairs NAADAC's ethics committee and sits on the core faculty of the School of Counseling at Walden University, tells *Addiction Professional* that in her home state of Colorado, influencers in the medical community are defining medication without counseling as an acceptable treatment protocol.

"This is really concerning," says Johnson. She adds, "Suboxone [alone] is not strong enough to keep someone from using."

Tuohy sees the same trend developing nationally. "The medication-only mindset is more prevalent. It bothers me," she says. "You can sew somebody up for a while, but understand that those stitches will come out." Not addressing other issues that lurk in the background of substance-using behavior can expose the patient to recurrence, she suggests.

NAADAC embraces a broader perspective about treatment that is embodied in its preference for the term "medication-assisted treatment and recovery," over "MAT" alone.

"Some will say about medication, 'That's all you need,'" Tuohy says. "As a person in long-term recovery, I know better."

**Reasonable expectations**

Many of Creative Treatment Options' outpatients enter the program directly from incarceration. In some cases, Smith says, "We're meeting the client at jail and going right to the doc's office," for a starting dosage of medication for OUD.

One of the organization's programs has a 50-week duration of medication treatment, a period much longer than seen in many specialty addiction treatment programs. Smith says that even for patients on extended MAT, however, Creative Treatment Options' ultimate goal remains one of helping patients move to a life not tied to medication, "if they can."

She says in nearly all cases the patient in early recovery is experiencing anxiety, and is highly motivated not to feel bad feelings. The person might see MAT as a way to erase these feelings, but Smith says that in recovery, “You have to tolerate things that are negative. A life worth living means feeling all feelings.”

She says of many patients, “They want to be as numb on the medication as they are on heroin. We discourage that.”

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