**We must start offering the most effective treatment
for opioid addiction to those who need it**

We must stop withholding our only life-saving treatment – the only treatment that reduces opioid overdose deaths: *medication treatment.*
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We must – *finally* - start ensuring access to ***effective*** treatment for opioid addiction and overdose prevention.

Tragically, ineffective treatment is the norm; it is all that most U.S. residential treatment programs offer for opioid use disorder (OUD): that is, psychosocial treatment only, without maintenance OUD medication (Beetham 2020) (Huhn 2020). Also, discrimination by recovery services against people in need of maintenance OUD medication is a problem (LAC 2022).

Methadone and buprenorphine are the most effective treatments for most people with moderate to severe OUD, combined wherever possible with psychosocial treatment and recovery support. Injectable naltrexone also has an important role.

Isolated psychosocial treatments (counseling, groups and/or related services by licensed professionals), when provided without medication, have not been shown to be effective - on their own - for OUD; they do not reduce overdose deaths. (Although they may be appropriate on their own for those with mild or recent onset OUD, or for those who are informed of and offered medication treatment but decline).

Current evidence indicates that counseling or psychotherapy do not increase retention in buprenorphine treatment or improve abstinence rates. However, methadone or buprenorphine treatment without concomitant counseling is known to be vastly superior to no treatment. This was reiterated in a [2021 review](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7398847/)  published by Dr. Nora Volkow, Director of the National Institute of Drug Abuse (Volkow 2021).

According to the National Institute of Drug Abuse, “Decades of research have shown beyond doubt the overwhelming benefit of medication for opioid use disorder (or MOUD). The full opioid agonist methadone (in use for half a century) and the partial agonist buprenorphine (approved two decades ago) have proven to be life-savers, keeping patients from illicitly using opioids, enabling them to live healthy and successful lives, and facilitating recovery. [Injectable] naltrexone … is also effective for patients who do not want to use agonist medications and are able to undergo initial detoxification under medical supervision. The efficacy of MOUD has been supported in clinical trial after clinical trial, and MOUD is now considered the standard of care in treatment of OUD, whether or not it is accompanied by some form of behavioral therapy. Yet even now, only half of addiction treatment facilities offer any FDA-approved medications. . . .And while recovery supports like 12-step groups can be a useful adjunct to treatment, many continue to discourage participants from taking medication—a legacy of decades of misconception that medication substitutes one addiction for another.” (NIDA 2022).

Psychosocial interventions are an important part of comprehensive treatment for OUD for all patients, especially those with co-occuring mental health symptoms, vocational, residential or social instability, and should be readily available, offered and encouraged for those who need treatment.

However, for those unwilling or unable to participate, psychosocial treatments should not be a condition of medication treatment for OUD according to the World Health Organization (WHO 2009), the American Society of Addiction Medicine, (ASAM 2020) the National Academies of Sciences, Engineering, and Medicine (NASEM 2019) and others because the barrier created by *required* comprehensive treatment can be insurmountable for many affected individuals.

This ‘medication-first’ or ‘low threshold’ approach, when needed or preferred by those seeking treatment, is especially helpful for those for those who are ambivalent or unlikely to initiate treatment or who discontinue treatment prematurely (i.e., the *majority* of individuals with OUD). Importantly, this approach reduces the immense barriers to treatment that exclude many or most with OUD. ‘A medication first’ approach reduces serious harms, saves lives, and often leads to comprehensive treatment that includes psychosocial interventions as people begin to improve with medication over time.

Low rates of participation and retention in treatment are due in large part to misunderstanding about the role of medication (‘medication stigma’). This often occurs even where medication treatment is offered if patients have been influenced by attitudes that medication should only be short-term. Medication stigma also contributes to the widespread use of ineffective OUD treatments, and is likely to be one of the main reasons we have failed to control the overdose epidemic. Unfortunately, patients and their families commonly believe that recovery does not begin until they are off of medication, or that medication is “trading one addiction for another.” (“addiction” is the wrong word for medication treatment). In reality, methadone, buprenorphine or injectable naltrexone are often needed for a number of years, or indefinitely, and can allow people to feel and function normally in society.

Stop Stigma Now ([www.stopstigmanow.org](http://www.stopstigmanow.org)) works to reduce stigma and discrimination directed against people with opioid use disorder, and their treatment.

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(excerpt: “Psychosocial services should be made available to all patients, although those who do not take up the offer should not be denied effective pharmacological treatment.”)

 StopStigmaNow.org 1-5-2023