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# STIGMA: THE GREATEST BARRIER TO EFFECTIVE TREATMENT OF OPIOID USE DISORDER

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(With full references; the version in the Maryland Medical Journal was limited to only 3 references).

The widespread use of ineffective treatment for opioid use disorder (OUD) is a major obstacle to addressing the opioid crisis. This is related to stigma and misunderstanding of our most effective OUD treatment: medications for OUD (or MOUD). Methadone and buprenorphine are the only treatments shown to reduce overdose deaths, and are the "gold standard" for most individuals with moderate to severe OUD (1, 2, 3, 4, 5, 6). There is an important but more limited role for long-acting injectable naltrexone (3).

According to the National Institute of Drug Abuse in 2022, "methadone … and buprenorphine have proven to be life-savers … enabling [patients] to live healthy and successful lives, facilitating recovery… The efficacy of MOUD has been supported in clinical trial after clinical trial, and is considered the standard of care in treatment of OUD, whether or not it is accompanied by some form of behavioral therapy" (6).

Although some individuals, even some with severe OUD, have achieved recovery without MOUD, this is much less common. Individuals should be able to choose among treatment options in conjunction with their health provider, and informed of likely benefits and risks.

Surprisingly, ineffective treatment is all that most U.S. residential treatment programs offer for OUD, namely, psychosocial treatment only, without the option of maintenance OUD medication (7, 8). Also, many recovery residences limit or prohibit access to MOUD regardless of patient preference, a practice which does not meet the basic standard of care for OUD, and which is a form of discrimination that potentially violates federal law (9). Surprisingly, many of these recovery residences still receive quality certification from the Maryland Certification of Recovery Residences program (MCORR).

Mortality due to opioids has now impacted the general U.S. life expectancy, and opioid-involved overdose deaths have increased seven-fold increase in since 1999 (10). Yet only about 20 percent of people with OUD are estimated to receive any type of treatment in a given year (4, 11). For no other medical condition for which an effective treatment exists is that treatment used so infrequently.

Stigma, a form of stereotyping and discrimination, includes self-stigma, structural stigma and others. Structural stigma includes excessive rules and restrictions imposed on patients by treatment providers which result from, and also perpetuate, stigma, and can cause barriers to treatment.

"MOUD stigma" largely stems from conflating "addiction" with "physical dependence." Despite widespread misunderstanding that using methadone or buprenorphine is "trading one addiction for another," "addiction" is the wrong word for these medications. "Addiction" is a loss of control over something that causes harm (12,13).

Due to the slow delivery to the brain (analogous to a nicotine patch) and very long half-life, maintenance methadone and buprenorphine are not 'addicting' by the accepted definition. These medications are compatible with a normal ability to drive, and in stable patients a normal ability to raise children, function in society and work in virtually any occupation. (Although it is possible to intentionally use these medications to accentuate the acute effects of other drugs such as sedatives). Studies have indicated that some patients endorse that they have diverted buprenorphine "to get high," but the meaning of this phrase is unclear and does not necessarily indicate either harm or "addiction." The goal of minimizing diversion should be balanced with providing adequate, convenient access to these lifesaving medications. Diverted medication is most commonly used to manage withdrawal symptoms or to avoid using more dangerous substances, and is more common when access to MOUD is limited.

The literature is clear that psychosocial services (counseling) alone, without MOUD, whether inpatient or outpatient, are *ineffective* for the overwhelming majority with moderate to severe OUD, and puts patients at significant risk of return to use or fatal overdose. The results of randomized controlled trials of the benefits of counseling as a supplement to MOUD are mixed. These services should be available and encouraged in conjunction with MOUD, but mandatory psychosocial services can be barrier, so they should not be a strict condition of accessing MOUD (14, 15, 16).

Even stable patients should not be encouraged to taper off of MOUD, but patients' wishes should be respected. OUD is a chronic relapsing medical condition and most patients with moderate to severe OUD benefit from long-term medication treatment of at least several years. Many if not most benefit from longer-term or indefinite medication treatment, although some taper off and remain stable. All studies to date of MOUD tapering and discontinuation demonstrate very high average relapse rates (17).

A valuable resource for providers, patients and families is www.StopStigmaNow.org including uniquely effective videos of people on MOUD telling their stories. Providers can get advice and support from the Providers Clinical Support System (https://pcssnow.org/), the Maryland-DC Society of Addiction Medicine (www.md-dcsam.org or www.mddcsam.org), or from the author through any of the aforementioned websites).

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