STOP STIGMA NOW
MEDICATION FOR OPIOID USE DISORDER SAVES LIVES
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MOST RESIDENTIAL TREATMENT FOR OPIOID ADDICTION IS INEFFECTIVE

Treatment of opioid use disorder (OUD) can be highly effective, but prohibitions are rampant for medications for OUD (MOUD) which makes ***ineffective*** treatment the norm in most residential treatment programs ("Rehab"). Treatment without maintenance MOUD is all that most U.S. residential treatment programs offer for opioid addiction: psychosocial treatment only, without medication. (1, 2) (See www.StopStigmaNow.org – Residential Treatment). Prohibiting these medications is also common in recovery services (3) and other settings.

OUD is unique among substance use disorders in that medications are the primary treatment: essential for the great majority of those affected. Methadone or buprenorphine are the gold standard for moderate to severe OUD, combined wherever possible with social support & psychosocial treatment (counseling & groups). Injectable naltrexone is an important second-line treatment with a more limited role.

When combined with medication treatment, published evidence for added benefit of psychosocial treatment is mixed. (4) Still, psychosocial treatment with MOUD should be strongly encouraged and available in all OUD treatment as a standard of care.

However, the results of psychosocial treatments *without* MOUD are *not mixed*; they are clearly ineffective when used alone for moderate to severe OUD. Psychosocial treatments without MOUD may be appropriate for mild or recent onset OUD, or for those who are accurately informed of medication options but decline or are unable to use them.

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, (5) the American Society of Addiction Medicine, (6) the National Academies of Sciences, Engineering, and Medicine, (7) and the Substance Abuse and Mental Health Services Administration (SAMHSA) (8) because the barrier of mandated comprehensive treatment can be insurmountable for many.

Methadone or buprenorphine treatment without counseling is known to be vastly superior to counseling alone. This was reiterated in a review by Dr. Nora Volkow, Director of the National Institute of Drug Abuse. (9) According to the Director of the National Institute of Drug Abuse (NIDA), "Decades of research have shown beyond doubt the overwhelming benefit of medication for opioid use disorder (or MOUD). Methadone and buprenorphine have proven to be life-savers,

keeping patients from illicitly using opioids, enabling them to live healthy and successful lives, and

facilitating recovery. . . The efficacy of MOUD has been supported in clinical trial after clinical trial, and is the standard of care in treatment of OUD, whether or not it is accompanied by some form of behavioral therapy." (10)

This 'medication-first' approach can be especially important for those who are ambivalent or unlikely to initiate treatment (potentially most people with OUD). It reduces the immense barriers to treatment that currently exclude most people from OUD treatment. This approach can reduce harms, saves lives, and typically leads to treatment with psychosocial interventions as people become more able and ready to engage over time.

The notoriously low rates of participation and retention in treatment are largely due to misunderstanding about these medications ('medication stigma' or 'MOUD stigma'), even in MOUD treatment settings where staff may encourage patients to come off of their medication.

Unfortunately, patients and their families often believe that recovery does not begin until after medication, or that medication is "trading one addiction for another." In reality, medications for OUD may be needed for a number of years, or indefinitely, and can allow people to feel and function completely normally.

Medication stigma is related to the fact that methadone and buprenorphine are themselves opioids. However, they act very differently than illicit opioids or opioids for pain due to their very long half-life and the fact that they are delivered to the brain much more slowly than other opioids. This is why they almost never cause "addiction." **Drug 'addiction' is defined as a loss of control over a substance in spite of serious harms.** These medications do not cause harms; they reduce harms by treating addiction. They do not cause people to feel "high" unless misused (e.g., injected or combined with drugs or alcohol). As with all opioids, the body develops "physical dependence," which is *not* addiction. Similarly, nicotine patches are used to treat tobacco addiction. The nicotine in patches is delivered to the brain very slowly, so its effect is very different than nicotine in cigarettes. Nicotine patches are not very satisfying, do not cause cravings, and do not lead to addiction the way cigarettes do. Similarly, **methadone and buprenorphine are not very satisfying, do not cause cravings, and do not lead to addiction.**

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(2) Huhn, AS et al. Differences in Availability and Use of Medications for Opioid Use Disorder in Residential Treatment Settings in the United States JAMA Netw Open. Feb 7,2020; 3(2):e1920843. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760443

(3) Legal Action Center. **Opioid Use Disorder & Health Care: Recovery Residences.** People who take medication for opioid use disorder (MOUD), like methadone or buprenorphine, often experience illegal barriers to healthcare. (posted in 2022)

https://www.lac.org/assets/files/Recovery-Home-MOUD-Info-Sheet-Feb-2022.pdf

(4) Lent MR, et al. Adjunctive Psychosocial Interventions and Opioid Abstinence Among Patients Receiving Buprenorphine A Randomized Clinical Trial. JAMA Network Open. Vol. 9, No. 6 2026; 9;(6):e2619826.

(5) **World Health Organization Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence**. WHO Press, World Health Organization, Geneva, Switzerland. 2009, World Health Organization. ("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.") https://www.who.int/substance_abuse/publications/Opioid_dependence_guidelines.pdf

(6) The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. ("Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs. However, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management.") https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline

(7) **Medications for Opioid Use Disorder Save Lives**. National Academies of Sciences, Engineering, and Medicine. 2019. Washington, DC: The National Academies Press. ("Lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder."). https://doi.org/10.17226/25310

(8) **NEW 8. The Substance Abuse and Mental Health Administration (SAMHSA) Final Rule on Medications for the Treatment of Opioid Use Disorder.** 42 CFR § 8.12(f)(5)(i) in the Federal Register. Feb 2024. ("Patient refusal of counseling shall not preclude them from receiving MOUD.") https://www.federalregister.gov/documents/2024/02/02/2024-01693/medications-for-the-_treatment-of-opioid-use-disorder

(9) Volkow, ND & Blanco, C. **The Changing Opioid Crisis: development, challenges and opportunities.** Mol Psychiatry. 2021 January ; 26(1): 218–233. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7398847/

(10) **Five Areas Where "More Research" Isn't Needed to Curb the Overdose Crisis.** NIDA Director's Page. August 31, 2022 By Dr. Nora Volkow https://nida.nih.gov/about-nida/noras-blog/2022/08/five-areas-where-more-research-isnt-needed-to-curb-overdose-crisis

Updated 7-18-2026