



Medications for Opioid Use Disorder (MOUD): Overcoming Objections

Missourians struggling with substance use, including Opioid Use Disorder (OUD), should be screened for substance misuse wherever they seek help; those with OUD can be treated and referred for ongoing care. Providers and advocates are working to ensure that medications for addiction treatment are widely available in emergency departments and hospitals, primary care and mental health clinics, jails and prisons, residential treatment programs, and other care settings.

The need is urgent, since fentanyl (an extremely potent street drug) is increasingly responsible for overdose deaths for users of opioids and stimulants; the percentage of opioid overdose deaths involving fentanyl in Missouri increased from 12% in 2014 to 75% in 2018¹.

There are several evidence-based interventions that can help. One is MOUD, which includes FDA-approved medications, such as buprenorphine (Suboxone[®]), methadone, and naltrexone (Vivitrol[®]), often supplemented by behavioral treatment and social supports.

Missouri launched the Medication First approach in 2017, which provides rapid access to MOUD. The Medication First approach increases treatment access, which is best achieved through the integration of MOUD induction, stabilization, maintenance and referral through specialty programs, as well as mainstream health care.

A Medication First approach allows patients to first be stabilized on medication and then be brought into the appropriate level of care to fit their needs — thereby decreasing the risk of overdose and relapse. Another is harm reduction intervention. Harm-reduction philosophy emphasizes that patients should be kept safe until they are ready to seek treatment. Harm reduction services include

interventions such as dispensing naloxone, an opioid antidote that prevents death from overdose, and syringe service programs (SSPs) that provide syringe disposal, the procurement of sterile syringes, and linkages to treatment.

Despite data showing the success of MOUD in treating drug addiction, objections are still common. The following are some frequent objections and evidence based responses.

Why treat a drug addiction with a drug?

- Buprenorphine and methadone are shown to cut overdose death rates in half while decreasing illicit drug use and HIV₂ and hepatitis C₃ transmission, and improving patient retention in treatment.⁴
- Injectable extended-release naltrexone is shown to reduce illicit drug use and to increase retention in treatment in three- to six-month trials.⁵
- Patients on MOUD have lower health care costs compared to those on drug-free treatment.⁶
- Prison system data show that MOUD reduces deaths. Without treatment, the risk of opioid overdose death for people shortly after leaving prison is 129 times that of the general population.⁷
- After Rhode Island implemented the use of all three medications for opioid addiction in its jail and prison system, overdose death rates after release dropped by 61%.⁸

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About the Author

Donna Strugar-Fritsch, MPA, BSN, is a principal at Health Management Associates. She has more than 30 years of health care policy, program development, and clinical nursing experience.

Isn't drug-free, abstinence-based treatment better?

- Drug-free treatment is not as effective as MOUD in preventing deaths. See “[Dying to Be Free](#)” about the high overdose rates in a state where only abstinence-based residential treatment was available. Relapses and deaths are common as patients struggle to maintain abstinence, since strong cravings persist for years after last use.⁹
- Prison system data point to the benefit of MOUD in reducing deaths.¹⁰ After Rhode Island broadly implemented the use of MOUD in its jail and prison system, overdose death rates after release dropped by 61%.¹¹

Can people stop taking the medications?

- The American Society of Addiction Medicine recommends maintaining buprenorphine for at least one to two years, after which voluntary slow tapers can be attempted. People early in their disease can successfully taper off. If cravings come back, it is a sign that the taper was too soon.
- People with long-term opioid use may have permanent brain chemistry changes (see the free video “[Addiction Neuroscience 101](#)” for a simple and compelling explanation)¹² and require long-term treatment with MOUD.
- Lifelong treatment is acceptable for other chronic diseases such as diabetes, HIV, or high blood pressure. Addiction is a chronic brain disease that often requires a similar approach.

Medications should only be used short-term.

- Using medications for a brief period only, during the detoxification period, results in high relapse rates (82% relapsing after methadone taper¹³ and 92% relapsing after buprenorphine taper).¹⁴ Death rates double after buprenorphine tapers and triple after methadone tapers.¹⁵
- Ongoing treatment with buprenorphine or methadone significantly reduces drug

craving, which can last years after the initial detox period.¹⁶ Cravings increase the chance of relapse and decrease people’s ability to participate in recovery and rebuild their lives.

Buprenorphine is sold as a street drug. Isn't it just another way to get high?

- Buprenorphine diversion can be a sign of insufficient treatment access.¹⁷ Areas with high diversion tend to have low availability of legitimate treatment. Easy treatment access tends to decrease the amount of buprenorphine diverted to the illegal market.
- Most people who take illicit buprenorphine are taking it for its intended purposes (withdrawal management, detoxification, or relapse prevention), not to get “high.” In fact, buprenorphine’s chemical qualities (as a long-acting partial agonist medication) make it much more difficult to feel euphoria from buprenorphine compared to other drugs.¹⁸
- Patients who have taken illicit buprenorphine are more likely to stay in treatment once they start treatment.¹⁹
- In correctional justice settings, certain interventions can prevent diversion: doing mouth checks, requiring crackers to be chewed and swallowed before and after administration, and using liquid formulations.

Naloxone, the “rescue drug,” encourages risky drug use.

- Naloxone is an antidote, given by nasal spray or injection, which restarts breathing when someone is unconscious due to an overdose.
- Increased access to naloxone reduces mortality and has not been shown to increase drug use.²⁰
- Communities with increased access to overdose prevention education and naloxone have seen greater reductions in opioid-related overdose deaths.²¹
- Naloxone distribution is cost-effective, particularly when distributed to people using heroin.²²

People with addiction need to hit rock bottom — maybe go to jail — before they will change.

- This is a dangerous misconception of the nature of opioid addiction. Long-term opioid use alters brain chemistry in a way that produces uncontrollable cravings and intense despair that can persist years after last use. Hitting rock bottom frequently can result in overdose death from lethal street drugs or from mixing drugs.
- Through incarceration, people often lose jobs and housing, and emerge from the criminal justice system, making it much more difficult for them to get and stay in treatment after release, and more likely to resort to criminal activity to survive.
- More correctional justice institutions in Missouri are moving to treatment over incarceration, to avoid the risk of felony convictions leading to unemployment, homelessness, and recidivism.

Primary care clinicians aren't equipped for addiction treatment. Same for clinicians who work in correctional justice settings.

- Buprenorphine management is more straightforward than other medications used routinely in primary care, much like insulin.
- Many resources have been developed to help primary care physicians and clinic staff learn how to treat patients with addiction:
 - Through the Show-Me ECHO project, providers are learning more about the prevention and treatment of OUD through the OUD ECHO, the Certified Peer Support (CPS) ECHO, and the Pain Management ECHO.
 - The Missouri State Opioid Response grant offers training and technical assistance for providers through the Missouri Department of Mental Health, in partnership with the University of Missouri-St. Louis-Missouri Institute of Mental

Health (UMSL-MIMH) and the Missouri Coalition for Community Behavioral Healthcare.

- Buprenorphine is available as part of MO Healthnet (Missouri's Medicaid program) and most insurance plans without prior authorization requirements and is dispensed at pharmacies. Buprenorphine is a Schedule III controlled substance, which means it can be prescribed over the phone without a special prescription pad.
- Most patients can start buprenorphine at home, which decreases the burden on the office practice.²³ See links for patient-centered home induction instruction sheets in [English](#) and [Spanish](#), and this [buprenorphine quick-start](#) one-page reference.
- Through funding from the State Opioid Response grant, Missouri has started its first MOUD program in the St. Louis County Jail. This program was birthed out of the St. Louis County Public Health Action Plan to address opioid addiction and overdose, which included five areas of action: education and prevention, harm reduction and rescue, recovery, public health data, and treatment.

People with addiction who are in correctional justice settings use “free” buprenorphine as a heroin substitute and then go back on heroin when they get out of jail. That's a bad use of taxpayer money.

- As above, patients who have taken buprenorphine are more likely to stay in treatment or to seek treatment in the future. People with opioid addiction report that it was several experiences with buprenorphine — prescribed or illicit — that led to their eventual understanding of what “being clean” could feel like and to subsequently seek treatment.

Buprenorphine shouldn't be offered in practices that don't have robust treatment programs.

- Patients who can't afford counseling or can't afford the time off work can still benefit from MOUD practices that do not have behavioral health services. ²⁴ Access to medications alone is better than no access at all.
- Some practices deploy trained medical assistants, social workers, or nurses to help with patient support and monitoring.
- A medication-first approach allows people to access MOUD without requiring lengthy assessments and participation in counseling. See "The case for a medication first approach to opioid use disorder" ²⁵

Jails can't afford to add a new medication or program.

- Jail health systems have a powerful business case for streamlining access to MOUD to avoid the high costs of overdose treatment. MOUD has been shown to lower emergency department and hospitalization costs, lower hepatitis C and HIV rates, and decrease overdose deaths. ²⁶
- Compared to common medications for some chronic diseases, generic forms of MOUD drugs (buprenorphine, methadone, and oral naltrexone) are relatively inexpensive.
- Jails are obligated to care for all inmate health needs; they do not seek outside funding to cover the cost of, for example, a new blood pressure medication when added to the formulary.
- Individuals using opioids who receive MOUD have lower health care costs compared to those receiving opioid addiction treatment without medication. ²⁷

Opioid addiction is not treatable. People just keep relapsing.

- Addiction is a chronic illness, and relapse is part of the disease. It takes smokers an average of 30 or more attempts before they stop for good. ²⁸
- MOUD has about the same success rate as that for other chronic diseases requiring

difficult behavioral changes, and outcomes are as good as those for diabetes and COPD. ²⁹ Many people go on to reestablish productive, satisfying lives.

- The tragic impact of opioid addiction on individuals, families, and whole communities cannot be ignored when viable treatment is available and shown to have high success rates.

Methadone clinics are more about making money than getting people off drugs.

- Like most of the US health care system, the majority of opioid treatment programs (previously known as methadone clinics) are commercial or for profit.
- All of these clinics were founded as a mission to help people with addiction.
- Methadone providers are closely regulated by the federal government and state governments and must adhere to strict clinical practices. All patients on methadone receive counseling and close supervision, and clinical outcomes for individuals on buprenorphine and methadone are similar.

Summary

- MOUD are effective and are not difficult for providers to manage. However, integrating addiction treatment into health care settings requires culture change. Decades of misinformation has created a culture of blame and the false belief that willpower alone enables recovery.
- Learning to treat opioid addiction can be an organization's first step toward building skills to help patients with alcohol use disorder (which also benefits from medications) and other addictions that require intense behavioral therapy (like methamphetamine use disorder).
- Understanding the science behind addiction and treatment can help change perspectives from blame to compassion and a reduction in stigma. Addiction is a chronic disease and not a character flaw. Training in the concepts of **trauma-informed care** can help staff overcome bias and change practices. These talking points can help inform conversations to change hearts and minds.

About Missouri's opioid response:

The Missouri Opioid State Targeted Response (STR) and Missouri State Opioid Response (SOR) projects expand access to integrated prevention, treatment, recovery support, and harm reduction services for individuals with opioid use disorder (OUD) throughout the state. Grant dollars come from the Substance Abuse and Mental Health Services Administration (SAMHSA). The State of Missouri Department of Mental Health (DMH) is leading the project, with administration, implementation, and evaluation activities provided by the University of Missouri, St. Louis – Missouri Institute of Mental Health (UMSL-MIMH) – as well as healthcare agencies, academic institutions, people with lived experience with addiction, and other content experts from around the state. For more information, visit www.nomodeaths.org and follow along on Twitter @nomodeaths.

Endnotes

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