

“You’re Not Supposed to be on it Forever”: Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People who Use Opioids

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ABSTRACT: Opioid use disorder (OUD) through prescription opioid misuse, heroin, and illicitly manufactured fentanyl use has increased dramatically in the past 20 years. Medications to treat opioid use disorder (MOUD) is considered the gold standard for treating opioid use disorders but uptake remains low. Recently, Madden has argued that in addition to the stigma assigned to substance use and people with SUD, MOUDs also are stigmatized, a process she labels *intervention stigma* to distinguish it from *condition stigma* (ie, stigma of SUD). In this paper, we examine MOUD related stigma from the perspective of people who use opioids (PWUO) and key informants who play some role in providing or referring people to drug treatment. Providers and PWUO often viewed MOUD as one drug replacing another which discouraged providers from recommending and PWUO from accepting MOUD. MOUD stigma was also expressed by providers' exaggerated fear of MOUD diversion. The extent to which MOUD was accepted as a legitimate treatment varied and influenced treatment providers' perceptions of the goals of drug treatment and the length of time that MOUD should be used with many feeling that MOUD should only be used as a temporary tool while PWUO work on other treatment goals. This led to tapering off of MOUD after some time in treatment. Some providers also expressed mistrust of MOUD stemming from their previous experiences with the over-prescription of opioids for pain which led to the current crisis. Results from this study suggest that the proportion of PWUO on MOUD is unlikely to increase without addressing MOUD stigma among drug treatment providers and PWUO seeking treatment.

KEYWORDS: Substance-related disorders, methadone, buprenorphine, social stigma

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Introduction

Opioid use disorder (OUD) through prescription opioid misuse and heroin/illicitly manufactured fentanyl use has increased dramatically in the past 20 years, with an estimated 2 to 5 million adults suffering from OUDs each year.¹⁻³ OUDs are responsible for significant increases in morbidity and mortality from 1999 to 2010.⁴ Deaths due to opioid overdoses were the number one cause of accidental death in the US in 2018.⁵

National authorities on substance use treatment such as the Substance Abuse and Mental Health Services Administration (SAMHSA) have touted the effectiveness of medications to treat opioid use disorders (MOUD). Currently, 3 medications are approved to treat OUD. Methadone, an opioid agonist, has been available since the 1960s to treat OUDs but is restricted in the United States to administration through highly regulated Opioid Treatment Programs (OTPs), which often require direct observation of people taking their methadone. Buprenorphine, a partial opioid agonist, can be administered by any physician who has received a waiver from SAMHSA to prescribe buprenorphine. Buprenorphine is most often prescribed with naloxone to reduce overdose potential, with a brand name of Suboxone. Extended release naltrexone, an opioid antagonist

medication to reduce craving, was FDA-approved in the US for the treatment of OUD in 2011.⁶ However, while acknowledging that naltrexone may be appropriate for some patients, the scientific consensus is that opioid agonist forms of MOUD (methadone and buprenorphine) are the “gold standard of addiction care” and are the most effective for retaining people with OUDs in care and reducing illicit drug use.⁷⁻⁹

In spite of available medication options, the use of MOUD is low. The estimated gap between treatment need and capacity is 1 to 1.4 million people.¹⁰ Stigma has been argued to be one of the biggest barriers to effective treatment of OUDs.¹¹ As described in classic stigma models, people who use opioids (PWUO) are “discredited” because of their condition and may discredit themselves, a process called “self-stigma.”¹²⁻¹⁵ Recently, Madden¹⁶ has argued that in addition to the stigma assigned to substance use and PWUO, MOUDs are stigmatized, a process she labels *intervention stigma* to distinguish it from *condition stigma* (ie, stigma of SUD). Intervention and condition stigma can include public, self-, and structural stigma. She compared addiction treatment professionals who did and did not provide MOUD to differentiate between the stigma related to substance use and the stigma related to MOUD.



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Madden identifies 3 drivers of MOUD stigma: regulatory hurdles, treatment providers' own experiences with recovery, particularly among those who used a 12-step abstinence model, and lack of knowledge of MOUD. MOUD stigma is common among people with OUDs, some addiction specialists, other medical professionals, and the general public, and affects willingness to receive and prescribe MOUD. For example, research has shown that many people with OUDs are opposed to starting MOUD, feeling that it is "just another drug" or "replacing one drug for another," an opinion echoed by many in the public and in 12-step groups.^{11,17,18} Many providers also echo the belief that MOUD is "just another drug."^{19,20} Further, primary care physicians expressed concern that providing buprenorphine would "open the floodgates" to people with OUD, who were "difficult patients" and likely to be non-adherent or divert medications to non-prescribed uses or the street economy.¹⁹ Research has suggested that exaggerated and unfounded fears of diversion have negatively affected office-based buprenorphine treatment.²¹ Other research has shown that pharmacists hold stigmatizing attitudes toward buprenorphine and people with OUD and sometimes refuse to dispense it.²²

In this paper, we examine MOUD related stigma from the perspective of people who use opioids (PWUO) and key informants who play some role in providing or referring people to drug treatment. These participants include substance use treatment professionals, physicians who provided office-based MAT, OTP personnel, pharmacists, emergency department (ED) physicians, harm reduction personnel, first responders, and prosecutors, and judges from drug treatment courts. PWUO and key informants were recruited from 3 states, Connecticut, Kentucky, and Wisconsin, and included participants from rural, suburban, and urban areas. This paper contributes to the literature by exploring MOUD stigma among both providers and patients and how it affects treatment decisions. In particular, this paper will examine how MOUD stigma influences access to and decisions about MOUD, including whether it is recommended, provided or accepted, the goals of treatment, the length of treatment, the kinds of services that are provided with MOUD, and dosage. While the role of MOUD stigma plays a role in its low-uptake among both providers and patients, few studies have examined how it contributes to tapering and time-limits on MOUD. Most participants in this study saw MOUD as a temporary tool that could help PWUO meet other treatment goals. Current efforts to increase the prescription of MOUD may inadvertently lead to further stigma and mistrust of MOUD as providers and PWUO recall how prescription opioids like Oxycontin were marketed as safe and effective at the beginning of the opioid crisis.

Methods

Study overview

This paper reports on qualitative data collected in an urban, suburban, and rural area in 3 states: Connecticut, Kentucky, and Wisconsin. Study teams in each state conducted in-depth,

semi-structured interviews with 2 groups: key informants and people who use heroin, illicitly manufactured fentanyl or prescription opioids nonmedically. Key informants included drug treatment providers, including those who provide behavioral therapy and those who provide MOUD, first responders, pharmacists who filled buprenorphine prescriptions, harm reduction personnel, and drug court judges and personnel. Recruitment occurred through a combination of purposive sampling to recruit participants and snowball sampling. An initial list of key informants was identified using the expertise of the research teams in each state so that we had participants in each of the geographic areas (state and rural, suburban, and urban communities) and job categories listed above. Thereafter, participants were asked for the names of additional people who occupied similar roles and snowball sampling from initial recruits. One hundred sixty key informant interviews were conducted between January 2019 and February 2020 and took an average of between 30 and 60 minutes. Potential participants were emailed a brief description of the study and reasons for their eligibility. If interested, phone or face-to-face interviews were scheduled. Informed consent was obtained from all participants prior to the interview. All procedures were approved by the Institutional Review Board at the Medical College of Wisconsin. Key informants were not paid for participating in the study.

Study teams also recruited PWUO from rural, suburban and urban areas in each state. Initial participants were recruited from harm reduction services or upon entry to drug treatment facilities. Subsequent participants were referred to the study by PWUO who were interviewed by snowball sampling. Eligibility criteria included being 18 years or older and misusing prescription opioids or using illicitly manufactured fentanyl or heroin in the past 6 months. PWUO were compensated \$35 for completing in-depth interviews. A total of 148 in-depth interviews with PWUO were conducted.

Interview content

Key informants were asked about their perceptions of the role of MOUD in drug treatment, the goals of drug treatment and which types of drug treatment were most effective. PWUO were asked to describe initiation of opioid use and any transitions they made from prescription opioid use to heroin, illicit fentanyl, or injection drug use. In addition, PWUO were asked about any experiences they had with drug treatment, including MOUD, and experiences buying buprenorphine or methadone on the street.

Data analysis

All interviews were transcribed verbatim. The 3-state research team developed the initial coding tree in an iterative and collaborative process. We developed separate coding trees for key informant and PWUO interviews. A transcript was selected from key informants and read by the research team to develop

a preliminary list of codes. The preliminary coding tree was then refined through application to additional transcripts selected to reflect different experiences (eg, the sector to which the key informant belonged, state, local area). This process continued until the research team reached consensus on a final list of codes, their meanings, and the procedures for assigning them to text data. The research team then used MAXQDA software to apply the final list of codes to the transcripts. The coding was completed by 6 members of the multi-state research team. Coding, the development of new codes, and memoing (jottings done by coders to capture relationships between codes or initial hypotheses) were tracked by the 6-person team. We also used bi-weekly team meetings for troubleshooting and quality checks that included the principal investigator of the study. We used the same process to develop and refine a coding tree for PWUO and complete coding and analysis.

A constant comparative approach was used in analysis.²³ First, we identified quotes that focused on the stigma faced by PWUO and MOUD stigma. We then compared how key informants and PWUO and how key informants from different sectors felt about MOUD by comparing professionals working at behavioral drug treatment facilities with personnel at OTPs or physicians who provided office-based buprenorphine. We compared professionals at behavioral treatment facilities who did and did not endorse MOUD and looked for differences in state, city/town, or other factors. We also examined how drug court personnel, first responders and probation and parole officers felt about MOUD.

Results

Analysis of key informant interviews resulted in the identification of major themes. First, participants identified a clear “spill-over” effect of condition stigma on perceptions of MOUD and persons who receive it. Intervention stigma can be seen as an extension of condition stigma as PWUO are seen as difficult and untrustworthy by physicians who may wish to avoid treating PWUO with MOUD in their practices or communities. Further, condition stigma leads to exaggerated fears of MOUD diversion by providers. The extent to which MOUD was accepted as a legitimate treatment varied and influenced treatment providers’ perceptions of the goals of drug treatment and the length of time that MOUD should be used with many drug treatment providers viewing MOUD as a temporary tool that, by taking away cravings and withdrawal, allows PWUO to focus on meeting other treatment goals. Some participants also expressed mistrust of MOUD stemming from their perception of the over-prescription of opioids for pain in the 1990s which led to the current crisis.

Intervention stigma as an extension of condition stigma

Some MOUD stigma is an extension of stigma against PWUO. Residents often oppose establishing OTPs in their

neighborhoods for fear of having undesirable PWUO coming to their neighborhoods who then commit crimes and decrease public safety.

When we first opened up, uh, we were in one or two locations. . . . And then Art [pseudonym], who was the director, decided that there was a need to reach out and start establishing these [suburban and rural clinics]. And in every community that we’ve gone to, the public always resisted it. It was always something that they didn’t want in their town. They didn’t want a methadone clinic in their town. . . . The general public is a little naïve, I think, as far as, uh, the prevalence of the, of the opioid crisis within their community (Connecticut, urban MOUD provider).

The stigma against PWUO also influences physicians’ willingness to prescribe buprenorphine and pharmacists’ willingness to dispense it. PWUO are seen as difficult patients because they often have multiple comorbidities including mental illness. In addition, some physicians and pharmacists felt that substance users were dishonest and would expose their practices to risk, as patients might divert and sell their buprenorphine to others. Further, some providers felt that the presence of PWUO in their practices would make their other patients uncomfortable.

I will say that my journey on how I view Suboxone has changed probably 180 degrees from when I was a retail pharmacist to now. Often times, community pharmacists get frustrated and get very jaded because they’re dealing with sick people, obviously, but you’re dealing, when it comes to opioids, you’re dealing with people that in many cases you perceive are trying to get one over on you. They’re constantly calling you asking if they can refill something. You feel like the time you spend dealing with those patients seems disproportionately high compared to other patients we will see so you start to get a little bit of a cynicism about those individual patients and you start to look at them as not as human as you should. . . . And, when I was in retail pharmacy, I had those same frustrations and those same thoughts. I was not a fan of Suboxone. I felt like Suboxone was trading one addiction for another. (Kentucky, Medicaid reviewer)

As can be seen from the pharmacist’s quote above, MOUD stigma stems not just from it being a treatment for the highly stigmatized condition of illicit opioid use. He clearly expresses that he held stigmatizing beliefs about MOUD itself, including that it is trading one drug for another. Many PWUO shared these beliefs.

The effects of intervention stigma on treatment goals

Most of the substance use treatment providers who were interviewed for this research project accepted MOUD to some degree. There has been considerable effort to educate substance use treatment providers about the benefits of MOUD and dispel misperceptions and myths. Many providers, however, still felt that the purpose of substance use treatment was “recovery.” They defined recovery in a number of ways, but

most definitions involved a person growing spiritually and emotionally and making other changes in their lives, such as in their personal relationships, work and education. Some providers expressed the opinion that while MOUD could help a person become abstinent from illicit drugs, achieving sobriety without the aid of drugs was better. In their view, MOUD interfered with the emotional and spiritual change that needed to happen to gain true recovery.

I basically believe in abstinence-based treatment. Over the years, I have learned that abstinence is not enough. Abstinence helps a lot of different aspects of their lives and they do financially much better. They're paying off their bills much better. They have more stable relationships. . . . But as they achieve that, their motivation gets lesser and lesser and most of the programs that I have worked with, other than this program, do not teach you skills. . . . And we have a very difficult time teaching people that stress is going to be part of life. That's nothing any medication can do which will make the stress or anxiety go away and they don't want to learn that. . . . And as providers and therapists and everything else, we have to stress a lot more to it and that's one of the things that is not part of many, many programs that is so-called therapy provided, but they're not trained people. They don't know what they're doing. Even the physicians [who] were prescribing Suboxone has no background in addiction, you know. . . . Just be writing the medication, they really don't know what they're doing and that's where the culture has not changed around treatment of opioid addiction (Kentucky, Urban treatment provider who accepts MOUD).

Part of the feeling that abstinence, with the help of MOUD, is not enough probably stems from the process by which buprenorphine treatment is intended to be integrated into mainstream healthcare. Behavioral health providers may feel that their expertise is not valued as pills are seen as the solution to OUD.

PWUO also expressed the feeling that MOUD should be a temporary step in recovery.

Interviewer: So, how do you feel about methadone now?

Eh, I dunno. It's a touchy subject. There's a lot of people on methadone that use it for the wrong purpose. . . . They're on methadone and they have no, no plans on being clean or getting clean. They just don't wanna wake up sick, and they wanna be able to go out there and look for their drugs (Connecticut, urban PWUO)

Opinions that recovery needs to involve personal change and growth can serve to stigmatize MOUD and those who take MOUD who do not change, and thus are not "in recovery." Suffering, some believe, is part of the process necessary for real change. As one provider described, the cravings that accompany becoming abstinent from substances like opioids helps promote change. Without the discomfort of withdrawal and cravings, the motivation to change is reduced.

Ideally, I got sober. I don't know. I speak for myself but I got sober because I was so uncomfortable, I had no choice not to. Suboxone keeps me comfortable. Why change? (Kentucky, rural drug treatment provider)

Many providers who expressed a preference for abstinence-based treatment had their own experiences with addiction and recovery. Many of them had gone through a 12-step program, a model that is still dominant in the field as it is incorporated into many intensive outpatient and residential treatment programs, and something that is often recommended to or required of those who are part of drug treatment courts. While changing, many 12-step approaches still discourage MOUD and say that being on MOUD is not being "sober." Frustration about this attitude and how it serves to stigmatize MOUD and those who use it was expressed by the participant below.

Where I get a little hot is, there's a difference between taking medication and being a drug addict, and you can do that. What makes me really angry is treatment centers that – or this hybrid model of sober living/IOP [Intensive Outpatient Treatment], where they're like, "No, you can't be on it." I am not of a – aware of a place in this general area where I can send someone to sober living that is on buprenorphine. They won't allow it. And that's just the 12-Step community. . . . And that's adding to the stigma; that brings stigma back in again. (Wisconsin, suburban drug treatment provider)

Other providers were more accepting of MOUD but still saw recovery as more than just abstinence from opioids. For them, MOUD was a tool that could be used temporarily to reduce cravings so that the PWUO could focus on other aspects of their lives that needed changing.

I feel like ours is effective because – they come in for the medication, because it helps control the triggers or their cravings. But then, once they get stabilized on that medicine, they can get in counseling, either group-based counseling or individual, and they can address the issues that's going on. They can get to the root of what's going on and why they feel like – why they took the drugs initially. Why they feel like they need this, and what they can help them address those issues in counseling and then eventually taper down to where they don't have to take this medication anymore. (Kentucky, rural substance use provider)

Getting to the "root of the problem" suggests that PWUO have underlying mental health issues and that they need therapy to uncover their motivations for taking drugs. Substance use, according to this model, is a way to "self-medicate" these underlying issues. This is in contrast to viewing OUD as a "brain disease" which understands OUD as changes that happen in the structure of the brain due to prolonged use of opioids themselves. In this view, opioid use can be initiated for a variety of reasons in addition to underlying psychological distress.

Some providers stated that they would take PWUO off MOUD if they felt they were not sufficiently invested in recovery, which involves personal change and growth.

If they're just using Suboxone like a rolling locker, "As long as I have this medication, I don't have to think about anything else." So, are you doing any recovery? "No, I don't have time to do that." If I see that, if they're just using it solely, that's not my treatment

model. So, they're telling me how to treat them at that point. They need to be in some form of recovery. (Connecticut, rural office-based buprenorphine provider)

Other substance use treatment providers more fully embraced MOUD. They often did not view personal change or growth (ie, recovery) as an imperative for treatment, although they celebrated it when it happened. Many of these providers embraced a harm-reduction philosophy in which reductions in substance use were also seen as positive outcomes.

Success in treatment, it's a case-by-case basis. You know, we're not an abstinence-based program. We are a harm reduction-based program, you know. If somebody comes in and they stay on methadone for a while and they stop using and they're filling in all the blanks in their lives and they're providing for their children and working every day, they come down on their dose and they're good and then they taper off and live a drug free life for the rest of their life, yeah, that's the ideal situation because they came from using to not using. . . If I have patient that came in the door that was shooting 30 bags a day and after two months, he's down to like two bags a day and he's moving towards, you know, a goal, that's also a win. . . And the people that don't like work in that field, like they don't understand that. Like, you know, "They're still using." But, you know, they're using less, and we look at that as a win (Connecticut, urban drug treatment provider).

Some PWUO, like the participant below, also viewed MOUD with a more harm-reduction philosophy.

I think it's [MOUD] great. . . I don't think it's for everybody. I don't think everybody needs it, I think some people frown upon it, but me personally, this is a hundred times. . . I might not be completely sober. People might think you're still taking some type of drug, but you're not shooting dope. You're not risking your life. You're not going to die from taking Suboxone. You're prescribed it, you're monitored, they check your blood, they check your urine. I think it's just a great crutch to have if you feel you're not strong enough to just do it without it, which I mean, I've tried it without Suboxone and stuff like that. I don't plan on staying on Suboxone my whole life, but I plan on staying on it until I feel I'm ready to do it where I won't need the Suboxone and I can actually say no to the heroin (Wisconsin, suburban PWUO).

MOUD duration: Temporary tool or medication for chronic condition

The kind of treatment goal providers endorsed often determined whether they saw MOUD as a temporary tool or a medication which PWUO need to take long-term. Many who saw MOUD as a tool to help PWUO address other issues in their lives saw the use of MOUD as temporary.

That's my biggest – I think that's our biggest fail right now, is that we are putting all this time and energy into the methadone programs and the Suboxone and getting people Narcan availability, but if they don't have the understanding of why they're doing – because you're not supposed to be on methadone for decades and you're not supposed to be on the Suboxone for decades. (Wisconsin, urban Emergency Department provider)

Participants who saw MOUD as a temporary tool did not see it as getting at the "root of the problem" as above. These providers may have perceived having to stay on the MOUD for a long period of time as evidence that the medications do not really work; to them, MOUD does not "cure" the disease since PWUO must continue to take it.

For those who see MOUD as just another drug, continuing to take MOUD is prolonging substance use. These providers advocated tapering after a time period specified in advance and talked to patients about that time frame to prepare them for it.

Our goal is to taper everyone. We call ourselves a two-year program, so. And it's really about, when you start tapering, you really – it's about making them excited about it. This is a good thing. You're gonna finally have a life that's drug free eventually. (Kentucky, rural drug treatment provider)

PWUO also wished to taper off of MOUD, sometimes even in spite of the fact that their providers wanted to keep them on it longer term. While considering MOUD helpful, the participant below sees it as just another drug because it made him feel high and because discontinuing treatment will cause withdrawal symptoms.

I've been doing it [methadone] and it does help, it does, but at the same time, it's just—the one thing I don't get, you're trading one vice for another vice, you know what I mean? Like especially with the methadone. My God. I mean, I would take that, and within an hour it's like, "Holy shit." Feeling like I just stuck a fucking syringe in my goddamn arm. And I want to go down. I want to wean myself off. No. They don't want to wean me off. They want to get me up more.

Interviewer: And you've asked them to?

Yes. Yes. I'm like listen. They're like, "How long have you been a heroin addict?" I said six years. They said, "Well, then maybe it'll take you six years to get off the methadone." I'm like those withdrawals are ridiculous, and they last for damn near a month. (Wisconsin suburban PWUO)

Some providers interviewed viewed OUD as a chronic medical condition and cited the evidence of the increased effectiveness of MOUD when used longer term.

I think it varies between the individual, and I think that we shouldn't – it's a chronic illness, so why do we say it's a temporary treatment? And so, I think that's probably where we just don't – probably it's part of the stigma. (Kentucky, urban drug treatment provider)

These providers recognize that many people on MOUD wish to taper off it eventually. They described a cautious approach to tapering that is done in partnership with PWUO.

Usually, people don't want meds. . . In order to convince them to consider a medication with the idea or the optimism that "You will feel better with this." Usually, it's a bit of a negotiation of – then the next question is, "Will I have to be on this for my entire life?"

My response is, “Maybe not.” Then we can start to talk about this in six to 12 months. Best practice recommendations beyond that would be if you wean off at six to 12 months and you start to feel symptoms again, and this medication was helpful, we’re going back on the medication. Then you have to consider if this has happened once with a relapse of symptoms or recurrence of symptoms, what are the odds it’s going to happen again? Probably pretty good. So, with each successive episode are you thinking along the lines of at what point do you stop weaning and say, “I’m accepting that this might be something like hypertension, diabetes.” We don’t blink when it’s a lifelong treatment you’re signing onto. (Wisconsin, urban office-based buprenorphine provider)

Providers who advocated for long term use of buprenorphine were also reluctant to taper before a patient was ready because of the increased risk of overdose that may occur since tolerance has decreased as a result of being abstinent.

My personal goal, I would love to taper people off, but the challenge is that if you look at opioid use disorder as a chronic disease like I do, it’s very – it’s, it’s kind of a dichotomy because on the one hand, we want to taper. We want people to be able to get off of opioids altogether but you also alter people’s tolerance when you do that and so it makes them more susceptible to overdoses if they do relapse. (Connecticut, suburban office-based buprenorphine provider)

MOUD mistrust: Diversion and exploitation

Another way that MOUD stigma manifests is in providers’ exaggerated fear that buprenorphine will be diverted. This fear is also related to stigma directed toward PWUO, who are inherently seen as untrustworthy. This can cause some providers to see prescribing buprenorphine to patients as an unacceptable risk, as seen above, or to have a very low threshold policy when it comes to compliance with treatment protocols or buprenorphine adherence. Best practice has providers periodically take urine samples from patients to test for buprenorphine metabolites. Metabolites not being present indicates that patients have not been taking their buprenorphine and are possibly diverting it. What a provider decides to do after finding non-adherence varies, however, between taking the opportunity to counsel a patient further or refusing to prescribe to them. Others have switched to directly observed therapy for buprenorphine, as expressed by the provider below.

If a person fails to come in, they come in every day for 30 days. If that same person fails to come in for the second time, they come in every day for a year. . . Buprenorphine, it’s either a film tab or it’s a tablet. And it would be like putting a sweet tart under your tongue because it’s sublingual and it has to dissolve. And it takes forever. But they have to be there until it dissolves because otherwise, they can walk out and take it out of their mouth. So, it’s a very timely process, but we’ve learned. (Kentucky, suburban drug treatment provider)

Some providers who were opposed to buprenorphine argued that since it is sold on the street, it can be misused just like heroin and other opioids.

And I just think it’s something that really needs to be considered. Instead of creating customers, we’re really trying to help people. Yeah, they’re not going to die on Suboxone, but time and time again, we’ve seen them come in and it goes from, well, I smoked a little weed when I was 12 ‘til I’m 45 and now I’m intravenously taking Suboxone. Progresses. And it was always [I was] prescribed Suboxone in 2014. By 2019, I’m injecting Suboxone. And coming to a treatment facility, looking for a bed because now Suboxone stopped working. (Kentucky, rural drug treatment provider)

While this participant’s concerns about progression of substance use may be well-founded, concerns about injecting Suboxone are not. Suboxone, a combination of buprenorphine and naloxone, is formulated so that it will cause withdrawal symptoms if injected.²⁴ The participant may have been thinking of buprenorphine without naloxone and using Suboxone as a generic term for buprenorphine. However, buprenorphine has a ceiling effect and does not cause the feelings of euphoria obtained in other opioids.

Many PWUO reported buying buprenorphine or methadone on the street primarily to reduce withdrawal symptoms, as has been seen in previous research.²⁵

When there’s nothing else and a strip of Suboxone is like \$8.00 or \$10.00. So, if that’s four days of not being incredibly miserable it’s worth it. But that being said, I don’t know one junkie that would have \$20.00 and think, “I should buy two Suboxones because then I’ll be good for two weeks.” They’ll spend it on eight hours’ worth of heroin. (Wisconsin, urban PWUO)

In fact, many participants reported that they would wait to take buprenorphine until they were certain that they would not be able to obtain heroin or other opioids because as an opioid agonist, buprenorphine would interfere with the high that they would get from heroin.

You get mad because it prevents you for so many days, so you get pissed off that you found heroin and it didn’t have an effect on you. So, people did it as a last ditch effort because they were sick.

Interviewer: Okay, just for the sickness.

Interviewee: Exactly, but no high came from it, no. (Wisconsin, suburban PWUO)

Other providers were suspicious of the scientific evidence presented that buprenorphine has limited potential for misuse and is safe and effective for treating OUD. As they point out, prescription opioids such as Oxycontin were widely advertised as being safe and effective for treating pain with limited potential for misuse, but the over-prescription of such medications is what led to the current opioid crisis.

I think there’s a lot of stigma still about medically assisted treatment. I think there’s stigma because physicians and the pharmaceutical industry got us into this mess to begin with. And I think that it’s prudent to be suspicious of the pharmaceutical industry saying that this is going to fix everything because, so far, it hasn’t.

This has been out for a while, and there are people still dying and. . .there are still people using it illegally. . . So, you can get high from it. . . I think there's also an issue with some of these clinics being in it for the money and not interested in tapering somebody off. (Kentucky, urban drug treatment provider).

Again, as mentioned above, buprenorphine has a ceiling effect that makes it difficult to feel the euphoric effects of other opioids, and street users of buprenorphine are often using it to manage their withdrawal symptoms. This provider notes that MOUD has increasingly been promoted as the “solution” to the opioid crisis. This promotion by pharmaceutical companies and providers may increase stigma, as providers recall the previous marketing of Oxycontin and other prescription opioids as safe and effective. Like with prescription opioids, increased buprenorphine prescriptions contribute to large profits by pharmaceutical companies. Participants also felt that buprenorphine was a way for providers to make money. The fact that patients remain on buprenorphine long-term adds to this perception.

What's happened is that these clinics have popped up, largely pushed by the companies that have vested interest in selling Suboxone and methadone, largely pushed by firms that own “addiction practices.” They've recognized that there is a void in the market and the new regulation allows them to do this, so they're just filling the market void. For example, a Suboxone clinic or methadone clinic may prescribe you a Suboxone and methadone without wanting to decrease that because they do not have a vested interest in getting the patient off the drugs. Generally, a methadone clinic patient goes into the clinic and they keep increasing the doses until the patient says that “This is enough.” (Wisconsin, urban pain management physician).

Many PWUO also expressed the view that buprenorphine and methadone providers were more interested in making money than in the long-term health and well-being of clients.

So, I remember seven years ago is when it was bad. I was like 112 pounds. I was not good. So, I put my kids with their dads and I just went to La Crosse and tried to get help. Went to the methadone program, got away from my very abusive boyfriend at the time, and just tried and tried and tried. But the thing is, is over the last seven years, I've been in the program two times for methadone. I just stopped the methadone program here in Milwaukee about four months ago, five months ago. I weaned myself down to 3 milligrams and then I just stopped. It is a double-edge sword, the methadone clinic. I'm going to cry. Because it's a business, not a treatment center. . . That is not a fucking treatment center. You may see a counselor and you may have to follow some rules, but they're not there to help you. They're there to make their money. That's it. (Wisconsin, urban PWUO)

Drug treatment providers and PWUO were particularly skeptical of other providers who accepted cash only rather than insurance. In the past, many insurance plans would not pay for specific MOUD, and providers often felt that reimbursement rates from Medicaid were too low and the administrative burden too great

to accept Medicaid. According to some providers, prescribing doses that were too high became a way that drug users could fund their treatment by diverting and selling buprenorphine.

And just to give you a background on Suboxone, when the Suboxone was cash, everybody was getting four – which is the maximum 32 mgs of dosing. When the cash went out of the business, they all came down to two, two and a half. So, my inference from that is you sell two and you take two so you can pay a fee for the clinic. So, it was \$400.00 to \$500.00 a month. I mean somebody who's making \$773.00 a month paying 400 or 500 for the Suboxone you can make your own inference and guess. (Kentucky, suburban drug treatment provider who offers MOUD)

In the example above, the blame is put on providers, not patients, and both MOUD and those who provide it are stigmatized. However, the difficulties in finding insurance that adequately pays for MOUD is also a form of structural stigma against MOUD and patients who need it.

PWUO confirmed that they sold their buprenorphine. At times this was to pay for their treatment, and at other times, they used the money to buy heroin. The participant below mentioned that she preferred methadone because it was harder to divert and sell, meaning that she was forced to take it rather than illicit opioids.

I was on the suboxone and I pre-, I prefer to be on the Methadone Clinic because I can't sell it. If I'm on the suboxones, I could sell the suboxones to get high. . . I used to be on the suboxone program. I was on the suboxone program for three years and I ended up not going anymore because I was sick of getting my suboxone. I used to get 56 for a month and I used to go and sell 50 and keep 6 and be sick and buy – I used to sell them for \$3 and then I have to pay \$10 to get a, a damn suboxone to get off – that's crazy. (Connecticut, suburban PWUO)

This participant is referring to having to buy suboxone off the street when heroin became unavailable again to avoid withdrawal symptoms.

Discussion

Our results provide further evidence of the presence of MOUD stigma that is related to but separate from the condition stigma of having an opioid use disorder.¹⁶ Opposition to locating OTPs or providing office-based buprenorphine stems from the feeling that providing these services would attract PWUO who are undesirable and engage in criminal behaviors.²⁶ This is similar to much of the opposition to syringe services programs (SSP) and other harm reduction services as community members fear that such services will attract PWUO to their neighborhoods.²⁷ However, like SSPs and harm reduction services, MOUD is stigmatized in its own right. Harm reduction is seen as enabling continued drug use because some of the most harmful consequences of opioid use, like overdose and HIV or HCV infection, are reduced. MOUD is seen by some as “substituting one drug for another” and by others as a medication

that gets in the way of true recovery which involves not only abstinence from illicit drug use, but personal growth.

Our study included behavioral health providers who offered residential, inpatient, and intensive outpatient treatment programs, and OTP and office-based buprenorphine providers. While almost all drug treatment providers in our study accepted people on MOUD into their drug treatment programs, and many key informants prescribed or dispensed MOUD, many still had stigmatizing beliefs about MOUD. MOUD stigma shaped and was shaped by providers' different perceptions of treatment goals which, in turn, determined their attitudes about the duration of providing MOUD. Many treatment providers and PWUO saw MOUD as a temporary tool with the goal eventually to taper off MOUD and be completely "drug free." Thus, MOUD stigma influences not only whether substance use treatment providers provide and PWUO accept such medications, but also contributes to prescribing practices that may increase the chance of relapse and overdose. Less than half of the substance use treatment providers in this study advocated long term use of MOUD as suggested by medical guidelines. Interventions to reduce MOUD stigma are urgently needed including among providers already prescribing MOUD. Like the providers interviewed in Madden (2019), these attitudes often stemmed from providers' own experiences with recovery that were often based on 12-step programs. Twelve-step programs contribute to stigmatization as many groups are not accepting of MOUD.²⁸

Our results also reveal a tension between behavioral health providers and the increased medicalization of OUD, in which medication is considered sufficient to treat OUD. They complained that many prescribers of buprenorphine and methadone did not offer or even refer patients for counseling. Thus, many felt that physicians who did not have training in counseling or addiction medicine did not have the expertise to treat those with OUD. The landscape of substance use disorder treatment has changed with the introduction of buprenorphine and increased insurance coverage of SUD treatment with the passage of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act.²⁹ Increasingly, SUD is seen as a chronic condition best treated within primary health care settings.³⁰ Traditionally, SUD treatment occurred in specialty centers that were separate from medical systems. Staff of such programs were often counselors who had received some professional training after their own experiences with recovery, or those who received degrees in psychology or social work. To the extent that physicians were involved at all, they were charged with overseeing detoxification or treating the medical conditions of patients. Funding came from state and federal agencies and SUD treatment was seen more as a social or criminal justice problem than a medical problem.²⁹ To a large extent this paradigm still exists, as the majority of people with SUD are treated in specialized addiction treatment facilities.

Further, physicians have been reluctant to treat those with SUD because of stigmatizing attitudes toward PWUO and MOUD as seen above, but also because they feel they lack the training or resources to provide psychosocial support.^{19,31,32} Addiction counselors have not been well integrated into physician practices that provide buprenorphine to date. Involving addiction counselors into medical practices may increase the use of MOUD in medical practices and decrease the use of stand-alone specialty centers.

The role of pharmaceutical companies in promoting the wide-spread use of opioids to treat moderate pain which contributed to the current opioid crisis has led to mistrust of the claims of the safety and efficacy of MOUD. Particularly with buprenorphine, some providers worried that the push to prescribe a pill to treat OUD was very similar to the push to prescribe opioids to treat pain in the 1990s. Providers pointed out that prescription opioids were marketed as non-addictive in the 1990s and feared that there may be unforeseen consequences of buprenorphine prescription. A qualitative study in rural Kentucky similarly found that many pharmacists were wary of MOUD for this reason.²² Other participants went further and argued that buprenorphine clinics were similar to the "pill mills" that unscrupulously prescribed opioids which were then diverted to the streets. They were particularly concerned about clinics that only accepted cash, reasoning that most PWUO would not be able to afford MOUD without insurance, so must sell excess buprenorphine either to pay for their treatment or to pay for other drugs they may wish to use. As one provider pointed out, when Medicaid was expanded to cover MOUD and clinics began to accept this, average doses of buprenorphine decreased from 32 to 16 mg, as clients no longer needed the excess to sell for treatment. PWUO also expressed the opinion that the purpose of OTPs and buprenorphine providers was to make money, and that it was in providers' financial interest to provide MOUD long term.

While fears of MOUD diversion are not unfounded, some participants held erroneous beliefs about buprenorphine and its potential for misuse. Some believed that because many of their clients had used buprenorphine on the street, that buprenorphine could be used to "get high" like other opioids. Others argued that PWUO injected buprenorphine. In fact, most research suggests that PWUO who buy buprenorphine on the street use it to manage withdrawal symptoms or to reduce their other opioid use.²⁵ Buprenorphine has a ceiling effect and generally does not produce the euphoria that other opioids produce. Further, most buprenorphine in the United States, such as Suboxone, is prescribed in formulations that include naloxone which precipitates withdrawal if injected.

Addressing MOUD stigma is of utmost importance in efforts to combat the current opioid crisis. While efforts to increase the number of physicians who are waived to prescribe buprenorphine has had some success,^{33,34} many

providers who are waived are prescribing to far fewer patients than currently allowed under current guidelines.³⁵⁻³⁷ Others do not prescribe to people with OUD at all. The number of OTP clinics has essentially stayed the same in past decades with only a modest rise in recent years.³⁸ It is necessary to address physician stigma toward PWUO and to MOUD to increase the number of physicians willing to prescribe MOUD. It is also critical to address community stigma to increase the numbers of OTPs. Policy changes to loosen regulations surrounding buprenorphine and methadone treatment may work to diminish MOUD stigma. For example, while the requirements for training and providing psychosocial services have recently been lifted, obtaining an X waiver to prescribe buprenorphine is still required and may cause barriers to treatment, especially since those wishing to treat 30 or more patients still must receive training to provide buprenorphine. During the COVID-19 pandemic, OTPs began offering more take-home methadone doses, with little evidence of an increase in diversion.³⁹ However, on their own, these interventions are unlikely to increase MOUD uptake without more direct interventions to address MOUD stigma among providers and communities. Further, MOUD stigma must be addressed in order to increase demand for MOUD among PWUO who may also see it as “just another drug” and getting in the way of recovery.


Importantly, our results show that attitudes toward MOUD can change. As knowledge about MOUD increases, people see the positive changes that result when people with OUD take MOUD. Stigma reduction efforts should therefore use positive stories illustrating the benefits of MOUD. Our findings suggest that interventions should also address common misperceptions about MOUD, including misuse potential. Without this education, providers may see efforts to increase MOUD use with suspicion, believing that there will be unforeseen consequences of MOUD and that it is being promoted to benefit providers and pharmaceutical companies financially. Finally, better integration of behavioral health services with mainstream medical care could help reduce some of the concerns behavioral health specialists feel with just providing medications without other psychosocial interventions.⁴⁰ This may also increase doctors' willingness to prescribe buprenorphine, as research has shown that a lack of behavioral health expertise within clinics often acts as a barrier for doctors to provide buprenorphine.¹⁷ However, this may also further reinforce condition stigma of PWUOs as OUD is seen as a psychological flaw rather than a medical condition. Ultimately, the proportion of PWUO on MOUD is unlikely to increase without addressing MOUD stigma.

Author Contributions

JDG was responsible for the conceptualization of the project, analysis and writing of the paper. AS, HM and MD conducted interviews, coded and analyzed data. All authors read and provided feedback on drafts of the paper.

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