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INFORMATION BOOK:
MEDICATION TREATMENT FOR OPIOID USE DISORDER

WHAT IS OPIOID ADDICTION?

Opioid addiction is a long-term treatable medical condition that causes changes in the brain. These changes lead to loss of control over opioid use even when this is causing serious harm. The medical term for opioid addiction is Opioid Use Disorder (OUD for short). Opioids include pain pills, heroin and fentanyl. The chance of becoming addicted can run in families, and can be higher in people with a mental health disorder.

WHY USE MEDICATIONS FOR OPIOID ADDICTION?

Most people with opioid addiction who are treated *without* medication return to using drugs. Methadone and buprenorphine are opioid medications that are often needed to help people regain control over their lives, and over their use of illicit drugs. Naltrexone (Vivitrol) is also a medication for OUD. Addiction counseling, recovery support, and/or mental health treatments are also needed for many individuals, along with medication.

Methadone and buprenorphine can stop withdrawal symptoms, help reduce cravings allow people to lead normal lives, and greatly reduce the chance of dying from an overdose. Their gradual effects, lasting over 24 hours, allow people to feel well and function normally. Like the difference between nicotine patches and cigarettes, the very slow effects of these medications avoids addicting properties.

Decades of research have shown that **people who stay on medication for OUD are much more likely to lead healthy lives and stay in long-term recovery**. The effectiveness of methadone and buprenorphine to treat OUD is recognized by all major medical and health organizations. These include the U.S. Public Health Service, the U.S. Surgeon General, the American Medical Association, the American Public Health Association, the World Health Organization and others. On average, people with OUD who receive treatment with methadone or buprenorphine are healthier, live longer, are *less* likely to use illicit drugs, to be arrested, to have mental health symptoms, to get HIV or hepatitis or to die from an overdose. They are *more* likely to be employed, to have social connections and an improved quality of life compared to people who do not receive medication treatment. **These benefits are more likely with longer periods of medication treatment.**

Doctors, lawyers, teachers, students, programmers, engineers, people in skilled trades, husbands and wives, parents who take care of their children, are among the many people with OUD who function normally while taking medication treatment.

IS MEDICATION FOR OUD JUST TRADING ONE ADDICTION FOR ANOTHER?

NO. Methadone and buprenorphine are opioids, and if you stop taking them suddenly, you do have withdrawal symptoms. The medical term for this is "physical dependence." But addiction is much more than just withdrawal symptoms. There are long-term changes in the brain and psychological cravings for more and more of a drug even when this is causing serious problems. Patients on methadone and buprenorphine can be free of cravings and can regain control. 'Addiction' is the wrong word for methadone or buprenorphine.

People in stable treatment on methadone or buprenorphine are employed in essentially any occupation. Job performance is unaffected. Drowsiness does not occur unless the medication is used with other drugs, or if the dose was not right.

HOW LONG SHOULD THESE MEDICATIONS BE USED?

Medications for Opioid Use Disorder are most often needed for a number of years or long-term. OUD is typically a long-term or life-long medical condition with a long-term risk of returning to use. Most people who successfully meet their goals remain on medication treatment for a number of years or indefinitely. However, some taper off of medication and remain stable. OUD treatments without medication, or with short-term medication, have very poor results on average, with about 8 out of 10 people returning to drug use.

Even after gradually reducing ("tapering") and coming off medication, many people return to drug use, especially if medication is stopped within the first one to two years. People have the right to choose to taper off of medication whether or not the treatment provider thinks it is a good idea. People are not congratulated for coming off of medication because the goal of treatment is recovery with whatever tools a person chooses.

Those who taper off are also much more likely to have an overdose because of the loss of "opioid tolerance." This means the body is no longer used to opioids, so drug use is more dangerous. In other words, methadone and buprenorphine tend to protect against overdose to a significant effect. Injectable Naltrexone (Vivitrol) has not been shown to protect against overdose.

WHAT ARE POSSIBLE RISKS OF THESE MEDICATIONS LONG TERM?

Opioids including methadone, if used with alcohol or sedatives, can cause drowsiness or overdose. A methadone overdose could occur if it is increased too quickly. Any opioids, including methadone, can cause or worsen sleep apnea, and can be more risky with certain medical conditions. Any opioids could potentially reduce testosterone in men, which can cause sexual problems. Low testosterone could also cause low bone density, especially with other risk factors such as tobacco or alcohol use, HIV or poor nutrition. As a precaution, an EKG is done at certain doses of methadone, to see if there is any risk of a very rare irregular heart rhythm. All of these risks are lower with buprenorphine compared with methadone or other opioids. Otherwise, there are no significant long-term health risks from methadone or buprenorphine.

SHOULD I TELL AN EMPLOYER ABOUT MY MEDICATION TREATMENT?

Methadone and buprenorphine may or may not show up on an employment drug test for opioids; It is not necessary to tell an employer about them in most settings. (However, an application for a commercial driver's license may be an exception in the case of methadone). Employers may not discriminate against someone on medication prescribed or provided by a health provider. If either medication is found on an employment test, there should be a third party, a "Medical Review Officer," to verify that the medication came from a health provider and to report the test result to the employer as 'negative.'

METHADONE

Methadone has been used as a treatment for OUD for over 50 years. Patients who receive methadone treatment have become free of craving, without withdrawal, ready and able to work and to be fully engaged with their families and communities. Methadone is available in Opioid Treatment Programs (OTPs) which operate under federal and state regulations and can help with a variety of substance use disorders and other conditions.

The most common side effects of methadone treatment are constipation and sweating. Constipation can be treated with changes in diet, over-the-counter medications or a long-term prescription laxative if needed.

BUPRENORPHINE

Buprenorphine with naloxone (brand name "Suboxone" and others) is the most commonly used buprenorphine product. (The naloxone ingredient is essentially not absorbed and is added to discourage injection). Buprenorphine alone (brand name "Subutex" and others) is used in pregnancy. Here we use the term "buprenorphine" for either buprenorphine with naloxone or buprenorphine alone. Buprenorphine is typically taken sublingually (under the tongue) once per day. There is also a long-term formulation (brand name Sublocade) that is injected under the skin by a healthcare provider.

Methadone and buprenorphine are equally effective for most people, but methadone can be more effective for those who have been using larger amounts of heroin or fentanyl. Methadone (for addiction) can only be obtained at opioid treatment programs, with many rules and regulations, but buprenorphine is also available in some medical practitioners' offices and clinics. Buprenorphine is less likely than methadone to cause side effects, including drowsiness or an overdose, for example if the medication is combined with certain other drugs, prescription medications or alcohol.

INJECTABLE NALTREXONE

Injectable naltrexone ("Vivitrol") is also approved for OUD. Unlike methadone or buprenorphine, it is not an opioid, does not produce physical dependence, does not stop withdrawal symptoms, and there are no withdrawal symptoms when it is stopped. The older naltrexone tablet (taken by mouth) is rarely used for OUD because it is not very effective. (Naltrexone is also used to treat alcohol use disorder). Injectable naltrexone is an opioid blocker. The first dose has to be started after a person has stopped using opioids for about a week or more. It is used much less often than methadone or buprenorphine. Unlike methadone or buprenorphine, injectable naltrexone has not been shown to reduce overdose or death.

With less evidence of effectiveness, it is considered by many to be a second-line option, compare to buprenorphine or methadone, for most people who have significant opioid addiction, but it is an important option that may be preferred in some circumstances.

The decision whether to use a medication, or which medication to use, is up to the person seeking treatment in consultation with their healthcare provider. Unfortunately, less than a third of residential rehab programs in the U.S. offer either methadone or buprenorphine, the gold standards of OUD treatment.

WORDS HAVE POWER:

Words to describe drugs or treatment affect how people are treated or how they feel about themselves. We should use accurate terms like "a person with a substance use disorder," instead of "a drug abuser," or "a drug user." "Detox" refers to coming off of alcohol or illicit drugs, but reducing medication is called "tapering" (the medications are not toxins).
Drug screens should be described as "negative" or "positive" (for illicit drugs or unexpected results), not "clean," or "dirty." Treatments that do not include maintenance medications should not be called "abstinence based" or "drug free" treatments. People on methadone or buprenorphine who are not using illicit drugs are "abstinent" and "drug free."

ONLINE/IN-PERSON MEETINGS THAT WELCOME PEOPLE ON MEDICATION:

- SMART recovery: www.smartrecovery.org
- MARA (Medication-Assisted Recovery Anonymous) www.mara-international.org/
- or www.facebook.com/groups/451374255284619/
- LifeRing Secular Recovery www.lifering.org
- SOS (Secular Organizations for Sobriety) www.sossobriety.org
- Women for Sobriety https://womenforsobriety.org
- Crystal Meth Anonymous www.crystalmeth.org
- Methadone & Buprenorphine Discussion Support facebook.com/groups/MethadoneTreatment
- In The Rooms: www.intherooms.com/home/category/community-and-meetings/

PEER AND OTHER RESOURCES:

- Stop Stigma Now (www.stopstigmanow.org) developed this document.
- National Alliance for Medication Assisted Recovery: www.facebook.com/NAMARecovery/
- Article & 6-minute video: More OUD Treatment Needed: https://tinyurl.com/y2nu9faf
- The Addiction Treatment Forum: http://atforum.com
- Government information: https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions
- From the Drug Policy Alliance: https://drugpolicy.org/sites/default/files/aboutmethadone.pdf
- A new Movement to End Addiction Stigma: www.shatterproof.org/endstigma
- Help for people who face discrimination in housing, employment or medical care due to addiction or use of medication: www.lac.org/resource/mat-advocacy-toolkit

SHORT VIDEO STORIES ON MEDICATION TREATMENT:

http://bit.ly/GinterVideo1 http://bit.ly/GinterVideo2 http://bit.ly/GinterVideo3
http://bit.ly/JWoodsVideo http://bit.ly/CatherineVideo http://bit.ly/KurtVideo

SCIENTIFIC ARTICLES ON MEDICATION TAPERING:

"Behavioral interventions alone have extremely poor outcomes, with more than 80% of patients returning to drug use. Similarly poor results are seen with medication assisted tapering . . . "Longer periods of tapering (1–6 months) with methadone or buprenorphine are also ineffective in promoting abstinence beyond the initial stabilization period."

Bart G, Maintenance medication for opioid addiction: the Foundation of Recovery
J Addict Dis. 2012; 31(3):207. www.ncbi.nlm.nih.gov/pmc/articles/PMC3411273/

Of over 4,000 patients who started a methadone taper, 13% had a "successful taper" defined as remaining alive, reaching a dose ≤5mg per day, not re-entering treatment, and not having an opioid-related hospitalization within 18 months. These poor outcomes are consistent with the findings of prior analyses." (additional references cited).
(Note: those who tapered slowly over 52 weeks had a higher success rate of ~ 22%).

Nosyk B, et al. Defining dosing pattern characteristics of successful tapers following methadone maintenance treatment: results from a population-based retrospective cohort study. Addiction. 2012;107(9):1621
www.ncbi.nlm.nih.gov/pmc/articles/PMC3376663/

"All studies of tapering and discontinuation demonstrate very high rates of relapse."

pg. 40, 'Medications for opioid use disorder save lives.' National Academies of Sciences, Engineering, and Medicine. 2019. Washington, DC. The National Academies Press free: www.nap.edu/download/25310
Summary: www.ncbi.nlm.nih.gov/books/NBK541390/

A review of all 23 published studies with long-term follow-up of OUD patients (3 to 33 years), identified most subjects from methadone treatment programs. Of those still alive, abstinence rates decreased over time to about 30% or lower after ten years of observation, and remained stable thereafter. Death rates, mostly from overdose, increased over time and were 6 to 20 times that of the general population. Remaining in treatment for longer periods was associated with a greater likelihood of abstinence. Maintaining opioid abstinence for at least five years substantially increased the likelihood of stable abstinence. Hser Y-I et al. Long-Term Course of Opioid Addiction. Harvard Review of Psychiatry. Volume 23(2) 2015 Abstract: https://pubmed.ncbi.nlm.nih.gov/25747921/

"Patients who discontinue OUD medication generally return to illicit opioid use.". . Arbitrary time limits are inadvisable."

SAMHSA, Treatment Improvement Protocol 63 Updated 2020
Substance Abuse and Mental Health Services Administration.

A review of the published research literature on post-discharge outcomes after extended methadone tapering found that virtually all studies document high rates of relapse to opioid use after methadone treatment is discontinued.

Magura S, Rosenblum A. Leaving methadone treatment: lessons learned, lessons forgotten, lessons ignored. Review Mt Sinai J Med. 2001 Jan;68(1):62-74. http://bit.ly/leavingMTHD

STORIES OF REAL PEOPLE IN STABLE RECOVERY ON METHADONE:

These are quotes from real patients on long-term methadone maintenance prescribed in a doctor's office after they became stable in an opioid treatment program. From 'The Further Concealment of a Stigmatized Condition,' Ph.D. dissertation of Herman Joseph, City University of New York, 1995.

"I have always worked as a window cleaner on skyscrapers. I've never had an accident and work on scaffolds and even attachments to the buildings. I am considered a good worker and the men trust me. . . The methadone has no effect.

"Methadone has allowed me to be a mother, a wife and a business woman. Before I came into methadone treatment [about 15 years ago] After being addicted for about five years I moved to a therapeutic community for over a year . . . but when I got out I relapsed and entered the methadone program. Since then I have always worked. . . I have my own business which I developed on medical maintenance and work about 10 hours a day. . . . I am happily married with two beautiful daughters. . . Methadone is not substituting one addiction for another, it is a medicine, and it has not only saved my life but has allowed me to have a family, a home and business. . . I have no intention of getting off methadone."

"Within 2 weeks [of entering a methadone clinic] I got a job. . . My sister was on the methadone program, did very well and decided to taper off. She had friends and support. Everything appeared to be going well. Within a year she was dead from an overdose. I believe this is a physical problem. I don't get high or have any effects from the methadone and take it every day like a vitamin. We have a beautiful home, a child and I have a thriving business with employees. Everything is now normal."

"I consider addiction a physical condition like my arthritic condition. The methadone makes me feel normal and I am able to work. I do not feel anything when I take it. . . I am like your person next door. I have a family, own a home, and two cars."

"When I first entered methadone . . . my counselor advised me to go to college and I got a BS in electronics. Then I started to get jobs in the electronics field. . . . I began to build my own business, and now I am very successful with nine people working for me. . . . I am very successful -- more successful than my brothers who have technician jobs. . . . I am on 90 mg, feel fine, don't get high and am able to do all types of work without any effect from the methadone. My employees do not know that I am a patient."

"On methadone I was able to complete college and take professional courses. I now have a wonderful job which demands a lot of responsibility, education and skill. My boyfriend is also a patient and an engineer. . . At 90 milligrams I am able to function, don't feel high or have any effects from the methadone."