



MEDICATION TREATMENT FOR OPIOID USE DISORDER

Read online at 'www.stopstigmanow.org – SSN Materials'

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). The chance of becoming addicted can run in families, and there are other risk factors as well.

WHY USE MEDICATIONS FOR OPIOID ADDICTION?

The great majority of people with opioid addiction who are treated *without* medication return to using drugs. Methadone and buprenorphine are opioid medications that are needed by most people with OUD to help them regain control over their lives and their drug use. 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, and can block the effects of opioid drugs if they are used. These three features allow people to lead normal lives, and reduce the chance of dying from an overdose by 50 – 70%. 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 effect 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, including the U.S. Public Health Service, the U.S. Surgeon General, the American Medical Association, the American Public Health Association, the World Health Organization. On average, people with OUD who receive treatment with methadone or buprenorphine are *more* likely to live healthier, longer lives, to be employed, to have social connections and an improved quality of life. They 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, 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 they are stopped too suddenly, withdrawal symptoms occur. The medical term for this is “physical dependence.” But addiction is much more than just being at risk for withdrawal symptoms. Addiction causes long-term changes in the brain including loss of control over drug use and difficulty functioning. ‘Addiction’ is the wrong word for methadone or buprenorphine. People on these medications can excel at essentially any job including many jobs that involve driving. On the right dose, the ability to function is not affected by these medications in any way and drowsiness does not occur (unless also using certain other medications or drugs, or with health conditions that can cause drowsiness). Perhaps the greatest barrier to treatment is medication stigma, a form of misunderstanding and discrimination about the use of methadone or buprenorphine that too often prevents people from accessing these life-saving medications.

See: www.bit.ly/MOUD-stigma

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 have successfully met their goals have remained 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 reducing (“tapering”) and coming off medication very gradually, 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 of buprenorphine or methadone are less protected from an overdose. They no longer have protective “opioid tolerance” (meaning the body is no longer used to opioids). These medications reduce the risk of overdose by about 50 – 70% while they are continued. This is because they both “block” the effects of other opioids, at least partially, so people are much less likely to feel the effects of fentanyl, for example, or to die from it.

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 riskier 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. Except for people with certain medical conditions, there are no significant long-term health risks from methadone or buprenorphine otherwise.

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, taken once a day, 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 (for OUD) is only 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. Historically, methadone required frequent visits to an OTP, but regulations are changing and more OTPs provide many more take-home doses than in the past. The most common side effects of methadone treatment are constipation and sweating. Constipation can be treated with changes in diet, with over-the-counter medications, or a prescription laxative if needed.

BUPRENORPHINE

Buprenorphine with naloxone (brand name "Suboxone" and others) is the most commonly used form of buprenorphine. Naloxone is added to discourage injection. Buprenorphine alone is used in pregnancy. We use the term "buprenorphine" for either buprenorphine with naloxone or buprenorphine alone. Buprenorphine is typically taken under the tongue once daily. There is also an injectable buprenorphine (Sublocade) that is given monthly, and a possible new brand that may be injected weekly or monthly.

Methadone and buprenorphine are equally effective for most people, but methadone can be more effective for some who are more severely addicted. Buprenorphine is available at OTPs and in some medical practitioners' offices and clinics. Buprenorphine is less likely than methadone to cause side effects, including drowsiness or an overdose.

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 help 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. Injectable naltrexone, which is an opioid blocker, is started about a week after a person has stopped using opioids. It is not used as often as methadone or buprenorphine. Unlike methadone or buprenorphine, injectable naltrexone has not been shown to reduce fatal overdoses. For most people with significant opioid addiction, it is a second-line option, compare to buprenorphine or methadone, but it is an important medication that may be preferred by some people and in some circumstances. (See https://bit.ly/naltrexone_secondline). Injectable naltrexone is also used to treat alcoholism.

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, only a third of residential rehab programs in the U.S. offer maintenance treatment with methadone or buprenorphine.

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,” “a drug user,” or “addict.” “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.crystallmeth.org
- Methadone & Buprenorphine Discussion Support [facebook.com/groups/MethadoneTreatment](https://www.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/
- 6-minute video: More outpatient medication 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
- Discrimination in recovery houses against people on MOUD is often illegal: <https://www.lac.org/assets/files/Recovery-Home-MOUD-Info-Sheet-Feb-2022.pdf>

SHORT VIDEO STORIES ON MEDICATION TREATMENT:

Although videos about addiction stigma are common, it is rare to find authentic, short (1-2 minute) videos by real people telling their stories about how they are benefiting from maintenance medication as a part of their *recovery*: See www.stopstigmanow.org/media-library

SCIENTIFIC ARTICLES ON MEDICATION (more at www.stopstigma.org – Resources – Scientific Articles)

“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 ...”

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, consistent with the findings of prior studies.

(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/

“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 brief summary of ‘medication stigma’ and the role of medications for OUD.

Adams, Joseph A. **Stigma: The Greatest Barrier to Effective Treatment of Opioid Use Disorder.**
Maryland Medical Journal. March 2023; Volume 24 (1):7
Link at www.stopstigma.org – Resources – Scientific Articles.’

“Methadone ... and buprenorphine have proven to be life-savers ... enabling [patients] to live healthy and successful lives, and 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.”

Five Areas Where “More Research” Isn’t Needed to Curb the Overdose Crisis. August 31, 2022

By Dr. Nora Volkow, Director, National Institute on Drug Abuse.

<https://nida.nih.gov/about-nida/noras-blog/2022/08/five-areas-where-more-research-isnt-needed-to-curb-overdose-crisis>

Virtually all studies document high rates of relapse to opioid use after methadone 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. Free: <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."

"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."

When posting this document or an excerpt, please link to www.StopStigmaNow.org as the source.

LEGAL DISCLAIMER: Material contained on these pages is for informational purposes only and not intended to be a substitute for professional medical diagnosis or treatment. Be sure to seek the advice of a qualified healthcare provider about your individual situation.