



MEDICATION FOR OPIOID USE DISORDER HANDOUT

Opioid Use Disorder or “**OD**” 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 it causes serious harms. A significant majority of people with moderate to severe OD who are treated *without* medication continue to use drugs and are at risk for serious harms including overdose. Medications for OD (“**MOD**” or “**MAT**” for ‘Medication Assisted Treatment’) are needed by most people with OD to greatly reduce these risks.

Methadone and buprenorphine treat withdrawal symptoms, cravings, and block or reduce the effects of opioid drugs. They can allow people to feel completely well and to function normally. They are the only OD treatments of any kind shown to reduce overdose deaths.

There is a consensus among medical and health organizations that FDA-approved medications are the primary treatment for OD. People using methadone or buprenorphine are more likely to remain healthy, to remain in long-term recovery, to be employed, and 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. **These benefits are more likely with longer periods of medication treatment.** People on these medications typically feel completely well, fully alert, and can excel in their chosen profession, including as a driver in most circumstances. (Except “habit-forming drugs” in general are usually not permitted for interstate commercial drivers).

SOME PEOPLE PREFER NOT TO USE MEDICATION

People with OD should have their concerns and preferences respected and should determine their own path to recovery together with a licensed medical professional who provides reliable information. Misunderstanding and stigma are widespread about methadone and buprenorphine, which are themselves opioids.

IS MEDICATION ‘TRADING ONE ADDICTION FOR ANOTHER’?

Methadone and buprenorphine act very differently than street opioids or opioids for pain and are delivered to the brain much more slowly. This is why they almost never cause “addiction.” **Drug ‘addiction’ is defined as loss of control over a substance in spite of serious harms.** These medications do not cause harms. They reduce harms by treating addiction.

They almost never result in feeling “high” unless misused (injected or combined with drugs or

alcohol). The body develops “**physical dependence**” to any long-term opioid, which is not addiction. They work in a similar way to nicotine patches used to treat tobacco addiction. The nicotine in patches is delivered to the brain much more slowly than nicotine in cigarettes, so it is not very satisfying, does not cause cravings and does not lead to addiction the way cigarettes do. Similarly, **methadone and buprenorphine are not very satisfying, do not cause cravings, and do not lead to addiction.**

WHAT ARE POSSIBLE RISKS OF METHADONE AND BUPRENORPHINE?

Like opioids for pain, the most common side effects are constipation, nausea, sedation, or dizziness. Any opioid can cause or worsen sleep apnea and can be riskier with certain medical conditions. Any long-term opioid could potentially reduce testosterone, which can cause sexual problems or cause someone to feel poorly. Low testosterone can cause low bone density, especially with other risk factors like tobacco or alcohol use, HIV or poor nutrition. Low testosterone can be treated if needed. As a precaution, an EKG is done at certain doses of methadone to check for a risk of a very rare but potentially serious irregular heart rhythm. These side effects and risks are lower with buprenorphine compared to other opioids including methadone. Except for people with certain medical conditions (e.g., sleep apnea), there are no significant long-term health risks from methadone or buprenorphine otherwise.

HOW LONG SHOULD PEOPLE STAY ON MOUD?

None of the published research has identified a group of people who have come off of medication for OUD without an increase in the risk of harms or overdose deaths on average. However, many people in long-term recovery have done well after coming off of medications.

According to the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update, “While there is limited research on optimal length of addiction treatment, available research generally suggests that longer duration of treatment results in better outcomes. Generally, treatment [with medication] for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is associated with more positive long-term outcomes. For patients treated with methadone, 12 months is considered the minimum, and some patients will continue to benefit from this treatment for many years. Treatment should be reinstituted immediately for most patients who were previously taking MOUD and have relapsed or are at risk for relapse.”

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol 63: Medications for Opioid Use Disorder, “The best results occur when a patient receives medication for as long as it provides a benefit . . . patients who discontinue OUD medication generally return to illicit opioid use even when it is done slowly and carefully. This is because the more severe form of OUD (i.e., addiction) is more than physical dependence. Addiction changes the reward circuitry of the brain, affecting cognition, emotions, and behavior. In a large retrospective study, only 13 percent of patients who tapered from methadone had successful outcomes (no treatment reentry, death, or opioid-related hospitalization within 18 months after the taper). Factors that predict better outcomes after tapering off include a longer period on medication treatment, abstinence from illicit drugs, and financial and social stability. Once stabilized on OUD medication, many patients stop using illicit

opioids completely and others continue to use for some time, but less frequently and in smaller amounts, which reduces their risk of morbidity and overdose death. . . Arbitrary time limits on the duration of treatment with OUD medication are inadvisable.”

PHSICAL DEPENDENCE WITH METHADONE OR BUPRENORPHINE

Like any long-term opioid, coming off too quickly leads to withdrawal symptoms. This is due to physical dependence, which is not addiction. It is potentially risky to come off any MOUD too soon, whether or not there are withdrawal symptoms. While on methadone or buprenorphine, a person is 'tolerant' to opioids, meaning they may not feel the effects of other opioids, and other opioids are less likely to cause an overdose. This may be why methadone and buprenorphine reduce the risk of overdose. But once off of these medications, opioid overdose is more likely even from smaller amounts of opioids than were used in the past, because tolerance has worn off.

DIFFERENCES BETWEEN METHADONE, BUPRENORPHINE & NALTREXONE

METHADONE (a "full agonist") fully binds to the opioid receptors in the brain, causing an opioid effect. Almost all opioids for pain, and street opioids, are also full agonists. It can be started during active use. Some people report better success with methadone than with buprenorphine, but buprenorphine is also highly effective in the great majority of people with severe opioid use disorder. Methadone is only available for addiction treatment in a highly regulated Opioid Treatment Program. Methadone could potentially cause an overdose, especially if starting a dose that is too high or increasing too quickly, particularly when not using usual amounts of opioids regularly (when tolerance is low). The blood level increases slowly, so the dose is increased gradually and it may take days or several weeks to feel well. Overdose is rare with methadone dispensed at a clinic, but could be higher with street methadone. Methadone overdose is more common when prescribed for pain than when used to treat addiction.

BUPRENORPHINE (a "partial agonist") partially binds to the opioid receptors, resulting in a reduced chance of opioid side effects, and additional safety due to the "ceiling effect." This makes overdose extremely rare because high doses have no additional effect. Overdoses in adults have been rarely reported when it was combined with large amounts of alcohol or other sedating drugs. It can be fatal for children, so precautions are definitely needed to prevent this, just as with methadone. Buprenorphine binds more tightly to the receptor than methadone, so it tends to kick other opioids off the receptor which could cause "precipitated withdrawal" when it is first started. This is unlikely when it is started when definite withdrawal symptoms have developed after stopping fentanyl (or another opioid). Another way to prevent precipitated withdrawal is to start buprenorphine with "micro-dosing" under the direction of a prescriber, i.e., starting with a very small dose and increasing very gradually while continuing the usual amount of fentanyl (or other opioid) until on a full dose of both opioids before stopping the fentanyl. Compared to methadone, buprenorphine is more available from various prescribers, as well as at most Opioid Treatment Programs. It is taken daily under the tongue, or by injection either weekly, every other week, or monthly.

NALTREXONE (an “antagonist” or blocker) blocks other opioids from binding to the receptor, with no opioid effect of its own, so it does not manage withdrawal symptoms and has less relief of cravings than methadone or buprenorphine. It kicks any other opioids off the receptor, so it is only started after being off other opioids for at least a week or more to prevent precipitated withdrawal. This makes it difficult for most people with OUD to start it. Only the long-acting injectable form (brand name: Vivitrol) is effective for opioid use disorder. (The injectable or oral form is also used for alcohol use disorder). Unlike methadone or buprenorphine, it has not been shown to reduce overdose deaths, and most people do not stay on treatment very long. For these reasons it is not considered to be a first - line option for most people with moderate to severe OUD, and has less of a track record than methadone or buprenorphine. As a non-opioid, it is less stigmatized (there is less judgement about it) than methadone or buprenorphine. It is an important option for those who prefer it, or possibly for mild OUD after taking availability and individual circumstances into account, after being accurately informed about all MOUD options by a licensed medical professional.

MEETINGS THAT WELCOME PEOPLE ON MEDICATION

- MARA (Medication-Assisted Recovery Anonymous) www.mara-international.org/
- SMART recovery: www.smartrecovery.org
- LifeRing Secular Recovery www.lifering.org
- SOS (Secular Organizations for Sobriety) www.sossobriety.org
- Burn the Stigma (alternatives to 12-Step Programs) <https://bit.ly/4v5WSnS>

PEER AND OTHER RESOURCES: (see www.stopstigma.org – Resources - ‘Allies’ for more)

- National Alliance for Medication Assisted Recovery: <https://namarecovery.org/>
- The Drug Policy Alliance: MOUD: Methadone and Buprenorphine
https://drugpolicy.org/wp-content/uploads/2025/09/DPA-MOUDFactsheet_InDesign-FINAL-3.pdf
- Legal Action Center - Help when facing discrimination in housing, employment or medical care:
<https://www.lac.org/resource/mat-advocacy-toolkit>

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