STOP STIGMA NOW
MEDICATION FOR OPIOID USE DISORDER SAVES LIVES
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MEDICATION FOR OPIOID USE DISORDER HANDOUT
PRACTICAL INFORMATION

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WHAT IS OPIOID USE DISORDER?

Opioid Use Disorder or "**OUD**" (sometimes called "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 they cause serious harm. The chance of becoming addicted is higher if there is a family history or with other risk factors, but it can happen to anyone.

WHY CONSIDER MEDICATIONS FOR OPIOID USE DISORDER (MOUD)?

The great majority of people with OUD (aka "opioid addiction") who are treated *without* medication return to using drugs. Medications for OUD ("**MOUD**" or "MAT" for 'Medication Assisted Treatment') are needed by the great majority of people with moderate to severe OUD to return to full functioning. OUD is different than other addictions in that medication is the primary treatment.

Methadone and buprenorphine can stop withdrawal symptoms, reduce cravings, and can block or reduce the effects of opioid drugs. They can allow people to feel completely well and to function completely normally. Methadone and buprenorphine are the only OUD treatments of any kind shown to reduce overdose deaths. (They reduce overdose deaths by at least 50%).

Decades of research on methadone and buprenorphine (together, known as "Opioid Agonist Therapy" or OAT) shows that people who stay on them are much more likely to lead healthy lives and stay in long-term recovery. The effectiveness of methadone or buprenorphine as the primary OUD treatments is recognized by every major medical and health organization that has weighed in on this, including the U.S. Public Health Service, the U.S. Surgeon General, the American Medical Association, the American Public Health Association, the National Academy of Sciences, and the World Health Organization. On average, people with OUD treated 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 those who do not receive these medications. (Less is known about the newest treatment injectable naltrexone; see below). People on MOUD excel in virtually any profession (as doctors, lawyers, scientists, drivers, etc.) like anyone else. **These benefits are more likely with longer periods of medication treatment.**

WHAT ABOUT PEOPLE WHO PREFER NOT TO USE MEDICATION?

It is important for people with OUD to have their concerns heard and their preferences respected. It is also important that people get reliable information from trusted, licensed medical professional and to allow each person to determine their own path to recovery in consultation with a medical professional. People should feel comfortable asking questions and expressing doubt. Misunderstanding and stigma are widespread about methadone and buprenorphine, which are, themselves, opioids. This 'MOUD stigma' is a major problem, but is understandable considering the many conflicting opinions that people are exposed to.

IS MEDICATION 'TRADING ONE ADDICTION FOR ANOTHER'?

Methadone and buprenorphine act very differently than street opioids or opioids for pain due to their very long half-life and the fact that they are delivered to the brain much more slowly than other opioids. This is why they almost never cause "addiction." **Drug 'addiction' is defined as a loss of control over a substance in spite of serious harms.** These medications do not cause harms. They reduce harms by treating addiction. Also, they do not cause people to feel "high" unless misused (e.g., injected or combined with drugs or alcohol). The body develops "physical dependence" to *any* long-term opioid, which is not addiction. Similarly, **nicotine patches are used to treat tobacco addiction.** The nicotine in patches is delivered to the brain very slowly, so its effect is very different than nicotine in cigarettes. Nicotine patches are not very satisfying, do not cause cravings, and do 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?

Methadone (and to a lesser extent, buprenorphine) has possible side effects similar to those of any opioids. The most common 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 such as tobacco or alcohol use, HIV or poor nutrition. 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. All of these risks are lower with buprenorphine compared with methadone and other opioids. 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 DO PEOPLE STAY ON MOUD?

It is recommended that any forms of MOUD be continued either indefinitely, or at least until a person is in long-term stable recovery for at least 1 - 2 years due to the chronic, relapsing nature of opioid use disorder. Many people have tapered off and do well long-term, but this is

hard to predict, and all published research to date shows much higher rates of return to use and overdose deaths in the months and years after coming off of MOUD, *on average*.

PHSICAL DEPENDENCE WITH METHADONE OR BUPRENORPHINE

As with any long-term opioid, once methadone or buprenorphine is started, coming off too quickly leads to withdrawal symptoms. It is potentially risky to come off any MOUD too soon, including naltrexone, regardless of 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 than were used in the past, because tolerance has worn off.

DIFFERENCES BETWEEN METHADONE, BUPRENORPHINE & NALTREXONE

(the three medications FDA-approved for Opioid Use Disorder)

METHADONE (a "full agonist") fully binds to the opioid receptors in the brain resulting in a strong opioid effect. 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 strictly regulated and is only available for addiction treatment in an Opioid Treatment Program (aka "methadone clinic"). Compared to buprenorphine, it has a somewhat higher risk of opioid-related side effects, as do almost all opioids for pain or street opioids. (These are also full agonists). Most people on a stable dose feel completely well, fully alert, and able to excel in their chosen profession, including as a driver (except it is prohibited for interstate commercial drivers). 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 over days or weeks, even when the dose is increased gradually. Overdose is extremely rare with methadone dispensed at a clinic, but could be higher with street methadone. (Most reports of methadone overdoses are due to methadone for pain from prescribers inexperienced in prescribing methadone).

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 very 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 is dangerous and 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 lead to "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 until on a full dose of both opioids before stopping the fentanyl. Compared to methadone, buprenorphine is much more available from a variety of prescribers. It is typically also available at Opioid Treatment Programs, and some people benefit from the structure in these programs. It is taken daily under the tongue, or by using various long-acting injection options 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 significant relief of cravings than methadone or buprenorphine (which effectively treat withdrawal symptoms and cravings). 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 clearly shown to reduce overdose deaths, and more people have left treatment early. It is considered a 'second-line' option for most people with moderate to severe OUD, while methadone or buprenorphine which have a better track-record and are preferred (first-line) treatments for most people. As a non-opioid, it is less stigmatized than methadone or buprenorphine. It is an important option for those who prefer it, or possibly for mild OUD, taking treatment access 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.stopstigmanow.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
- Government information: https://www.samhsa.gov/resource/ebp/tip-63-medications-opioid-use-disorder
- Shatterproof www.shatterproof.org/endstigma (Has a treatment locator)
- 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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