



A Straightforward Look at Medications to Treat Opioid Use Disorders

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Opiate Use Disorder in the U.S. — The Scope of the Crisis

2.1 million people in the U.S. have opioid use disorder (OUD).

Over **80,000** opioid overdose deaths occurred in 2023 alone.

Only **1 in 5** people with OUD received medications for treatment.

People with OUD are **13x more likely to die** than peers of the same age.

Medications like buprenorphine, methadone, and naltrexone **cut the risk of death in half.**

MAT vs. MOUD — Why Language Matters

Term	Meaning	Why It Matters
MAT	Medication-assisted treatment	Implies medications are just a supplement, not central
MOUD	Medications for opioid use disorder	Recognizes medication as a primary, evidence-based treatment

What is MOUD?

- **MOUD = Medications for opioid use disorder**
Used to treat individuals with opioid use disorder through **FDA-approved medications**:
 - **Methadone** — Full opioid agonist
 - **Buprenorphine** — Partial opioid agonist
 - **Naltrexone** — Opioid antagonist
- **Key goals**:
 - Reduce cravings and withdrawal symptoms.
 - Support recovery and prevent relapse.
 - Lower the risk of overdose and death.

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It's not a silver bullet!

Why Would a Client Need MOUD?

Opioid use disorder is a chronic brain disease, not a moral failure.

Cravings and withdrawal are powerful and can hijack decision-making.

MOUD reduces relapse and overdose risk dramatically.

It works—people on MOUD stay in recovery longer.

Every person deserves a chance to live, heal, and rebuild.

Is MOUD Cheating?

- No. MOUD is not cheating.

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 - Evidence-based treatment
 - A medical response to a medical condition
 - A path to stability and survival

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 - A path to stability and survival
- Recovery isn't one-size-fits-all. MOUD is real recovery.

Addiction vs. Dependency

Addiction

- Use of substances regardless of harm and consequences

Dependency

- Physical need
- Tolerance and withdrawal potential

List of MOUD



Methadone



Buprenorphine



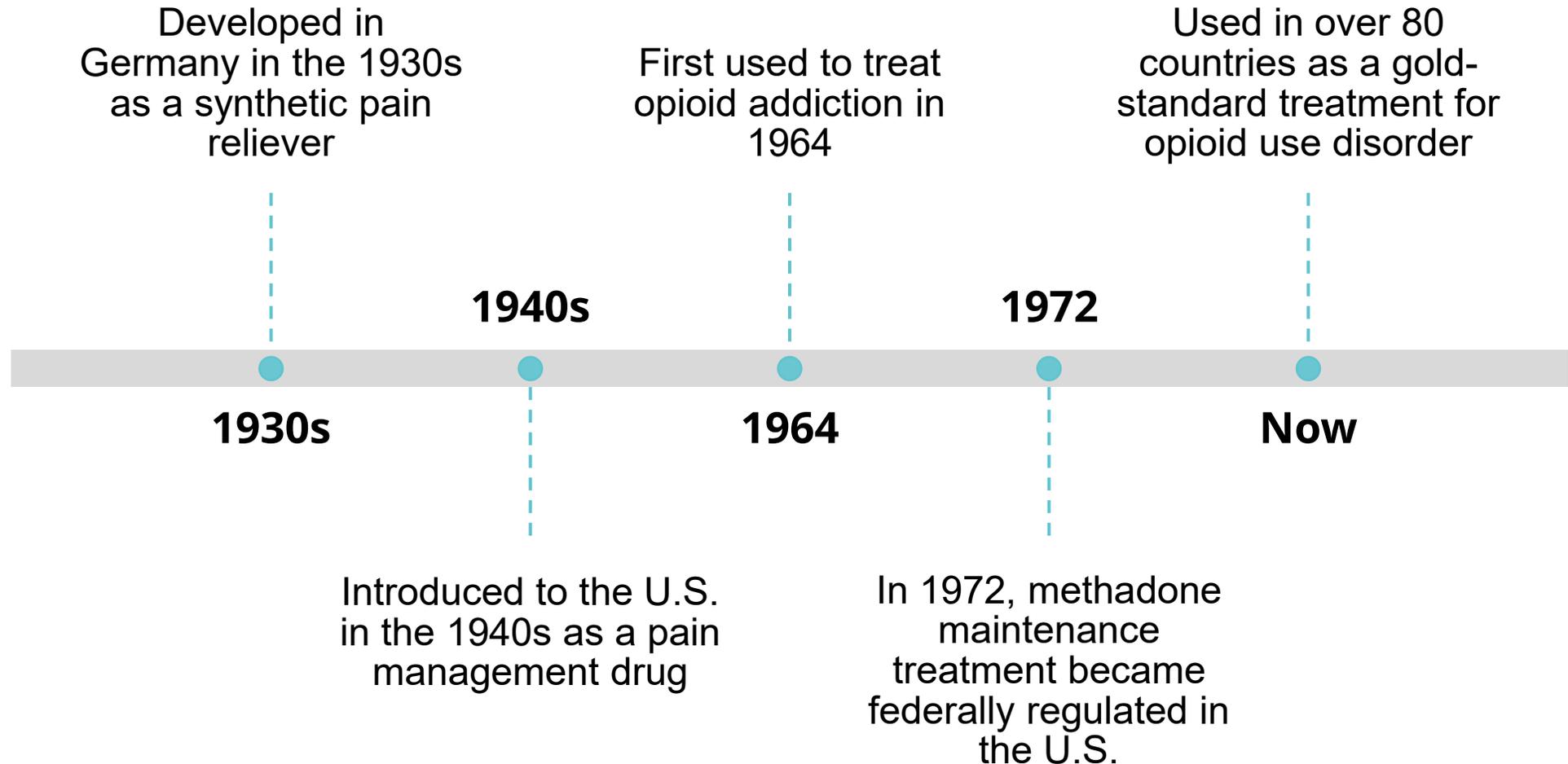
Naltrexone

Is Naloxone (Narcan) MOUD?

Naloxone (Narcan)	MOUD (e.g., methadone, buprenorphine, naltrexone)
Reverses overdose	Manages long-term recovery
Fast-acting, short-term	Ongoing daily or monthly use
Used in emergencies	Used as maintenance treatment
Available over-the-counter	Requires medical oversight or prescription

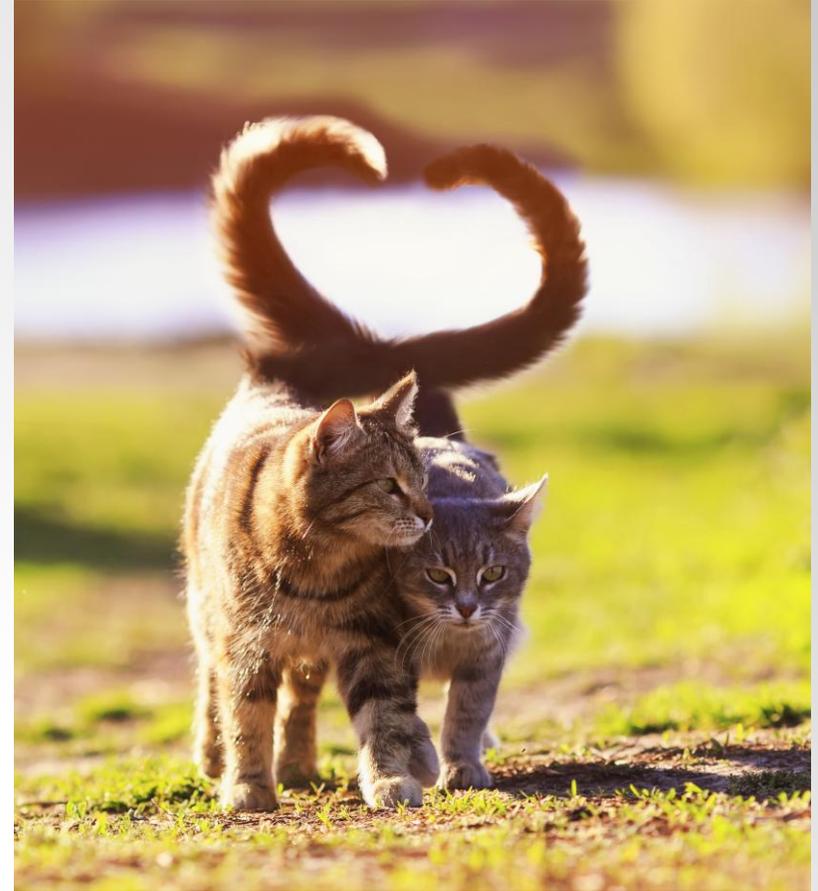
Methadone

History of Methadone



How does it work in the body?

- It is a **full opioid agonist**, like heroin and prescription opioids.
- Methadone works **just like other opioids**—but it's **legal, safe, and medically managed**.



The Good News

Must be taken **daily**
at a specialized
clinic (federally
regulated)

Risk of **overdose** if
misused or taken
with other sedatives

Can cause
sedation,
constipation, and
sweating

Potential for
diversion and
misuse outside of
clinic settings

Stigma—still often
viewed as “trading
one drug for
another”

Difficult to taper off
after long-term use
for some individuals

The Issues

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The Ideal Candidate for Methadone Treatment

- Individuals with **long-term or high-dose opioid use**
- People who have **tried and relapsed** after other treatment methods
- Those who experience **severe withdrawal symptoms**
- Patients with a **high risk of overdose**
- People who benefit from **structured, daily support**
- Individuals who do **not have regular access to a safe living environment**, where daily clinic visits provide routine and accountability

The Less-Than-Ideal Candidate for Methadone Treatment

- **Unstable transportation** or long distance from a clinic
- Inconsistent ability to attend **daily appointments**
- **Strong preference for privacy** (methadone clinics are public and often crowded)
- Employment or caregiving responsibilities that make daily dosing difficult

The Less-Than-Ideal Candidate for Methadone Treatment

(continued)

- History of **benzodiazepine or alcohol use**, which increases overdose risk
- Motivation for **less structured, more flexible treatment** (like buprenorphine or naltrexone)
- Individuals early in recovery who **feel overwhelmed by the daily structure**

Buprenorphine

Suboxone, Subutex, Sublocade, SubZol, Brixadi

History of Buprenorphine

- **Synthesized in the 1970s** as a safer alternative to full opioid agonists
- Originally developed for **pain management**
- Approved in the **1980s in the UK and France** for opioid dependence
- **U.S. FDA approved in 2002** for opioid use disorder (as Subutex and Suboxone)

History of Buprenorphine *(continued)*

- First opioid treatment allowed to be **prescribed in an office setting** (not just clinics)
- Expanded access with the **Drug Addiction Treatment Act of 2000 (DATA 2000)**
- Now used **worldwide** in OUD treatment and widely regarded as a first-line option
- Comes in films, tablets, and injectables

Subutex vs. Suboxone

Subutex	Suboxone
Buprenorphine only	Buprenorphine plus naloxone (Narcan)
Original mono-product	Combo product to deter misuse
Used more often in pregnancy	Used more often in general OUD treatment
No blocker if misused	Naloxone activates only if injected , causing withdrawal

The Narcan is Sleeping.



Unless it is injected in a vein...

- If suboxone is injected directly into a vein, the Narcan wakes up and becomes active
- What does the Narcan in the suboxone do if taken by mouth?
- Why do so many people say they are allergic to suboxone?



Injectable Buprenorphine

Feature	Sublocade	Brixadi
Active ingredient	Buprenorphine	Buprenorphine
Dosing frequency	Monthly	Weekly or Monthly
Approved for	Adults only	Adults (monthly), 16+ (weekly)
Start-up requirements	Must be on oral buprenorphine for 7+ days	Can be started after 1–2 days of oral buprenorphine
Injection site	Abdomen only	Abdomen, arm, thigh, or buttocks
Storage	Must be refrigerated	Room temperature (weekly), refrigerated (monthly)
Available since	2017	2023 (U.S.)

Buprenorphine





Fentanyl





Buprenorphine



How Does Buprenorphine Work in the Body?

- A **partial agonist** like buprenorphine:
 - **Activates the receptor** just enough to reduce cravings and withdrawal.
 - **Blocks other opioids** from entering (nothing stronger gets through).
 - Prevents the “party” without shutting the whole street down.

Precipitous Withdrawal

- If you take fentanyl/heroin and then take buprenorphine, the security guard will throw all the opiates out by the hair.
- If you take buprenorphine and then opiates, the security guard holds the gate closed and tells them to move along.



The Good News

Not intoxicating for people with opioid use disorder

Protects against overdose by blocking other opioids

Available in **pill, film, and long-acting injection forms**

Flexible — can be prescribed in regular clinics or primary care

Helps people say:

“I feel like myself again.”

The Bad News

Can cause precipitated withdrawal if started too soon after other opioids

Not strong enough for some individuals with very high opioid tolerance

Risk of **diversion or misuse** (though far less than with full agonists)

Some people metabolize it quickly and may struggle with coverage

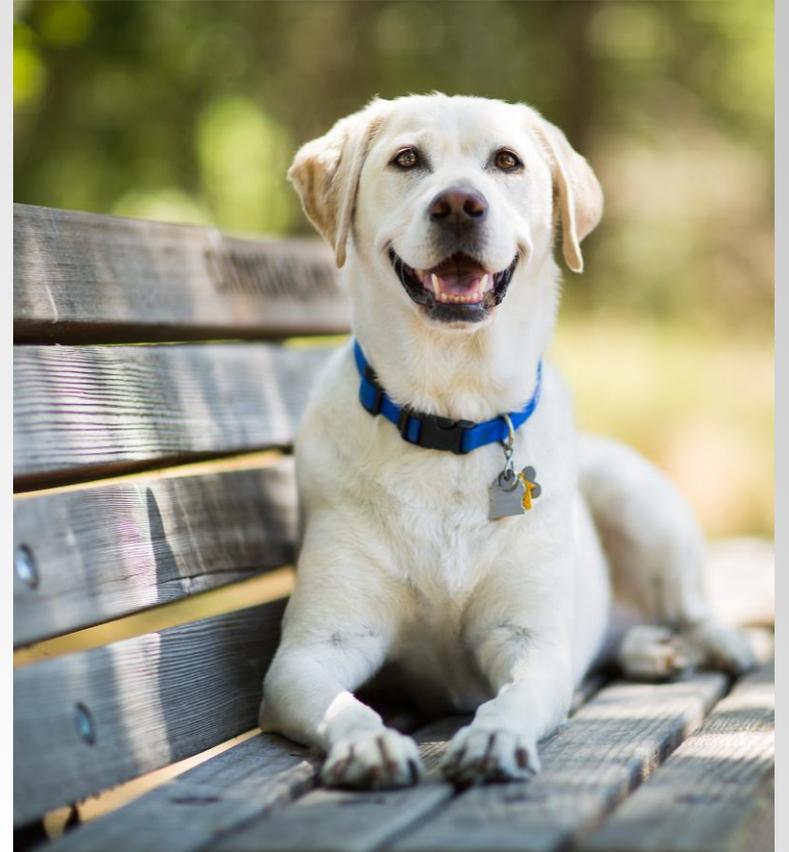
Stigma still exists, even among treatment providers and recovery communities

Can you get “high” on buprenorphine?

- **For most people with opioid use disorder:**
 - **No, buprenorphine does not cause a high.**
- **Why?**
 - Buprenorphine is a **partial agonist**, meaning it **activates the opioid receptor only partially**.
 - It has a **ceiling effect** — after a certain dose, **taking more won't increase effects**.
 - For someone with a tolerance, it **feels like stability, not euphoria**.

Then why to people abuse buprenorphine?

- **“If you ring a bell, the dog salivates.”**
 - Pavlov taught us that the brain **links cues to outcomes.**
- In addiction:
 - **The needle, the lighter, the bathroom, the car ride**
 - These can trigger **cravings** before the drug even appears.



The Ideal Candidate for Buprenorphine Treatment

Individuals who prefer **privacy and flexibility** in treatment

Those motivated to **take daily medication as prescribed**

Clients who cannot or prefer not to attend **daily clinic visits**

Pregnant clients (buprenorphine monotherapy is preferred)

Anyone needing a **low-barrier, outpatient recovery option**

The Less-than-ideal Candidate for Buprenorphine Treatment

- Those with **poor medication adherence** or struggling with co-occurring sedative use
- Clients who tried buprenorphine **multiple times without success**
- Clients needing **highly structured or supervised treatment** (e.g., daily accountability)

Naltrexone

Vivitrol — Injectable

History of Naltrexone

- **1960s** — First developed as an opioid receptor blocker
- **1984** — FDA approved for **opioid use disorder** (oral form)
- **1994** — FDA approved for **alcohol use disorder**
- **2010** — **Vivitrol**, the extended-release injectable form, approved for opioid use disorder
- Originally used after **detox**, aimed at people wanting a **non-opioid alternative**
- Now used for both **OUD and AUD**, especially in **criminal justice and abstinence-based settings**

Think of it as...

An empty seat with a “Do Not Use” sign

- It **occupies the space** so nothing else can bind.
- But it **doesn't do anything itself** — it just blocks others from getting in.
- It doesn't ease pain, reduce withdrawal, or stimulate the receptor — it just says, **“You're not allowed here.”**



The Good

Blocks opioid receptors—opioids won't work if taken

Non-addictive and non-intoxicating

No withdrawal when stopping

No risk of misuse or diversion

Available as **daily pill or monthly injection (Vivitrol)**

Can **reduce cravings** in some people

Ideal for people who want a **non-opioid, abstinence-based approach**

Helps people say: *“Even if I relapse, it won't work.”*

The Bad

- **Requires full detox before starting:** Patients must be opioid-free for 7–10 days to avoid precipitated withdrawal
- **Limited effectiveness for some patients:** Works best for highly motivated individuals or those with strong external accountability (e.g., legal system involvement)
- **Potential for overdose:** If a person discontinues naltrexone and returns to opioid use, their tolerance is lower—risk of overdose is higher
- **Monthly injection access/cost:** Extended-release injectable form (Vivitrol) can be expensive and may not be widely available
- **Less effective for pain management:** Because it blocks opioids, naltrexone complicates acute pain treatment if needed

The Ideal Candidate for Naltrexone Treatment

Individuals who have **fully detoxed** from opioids (7–14 days minimum)

People with **strong internal motivation** and a desire for a **non-opioid approach**

Clients in **structured environments** (e.g., recovery housing, justice-involved settings)

Those with a **history of diversion or misuse** of other MOUD

People with **co-occurring alcohol use disorder** (dual benefit)

Clients ready for a **“safety net” blocker** to prevent relapse

People transitioning off methadone or buprenorphine

Anyone seeking a **once-a-month, abstinence-based option**

The Less-Than-Ideal Candidate for Naltrexone Treatment

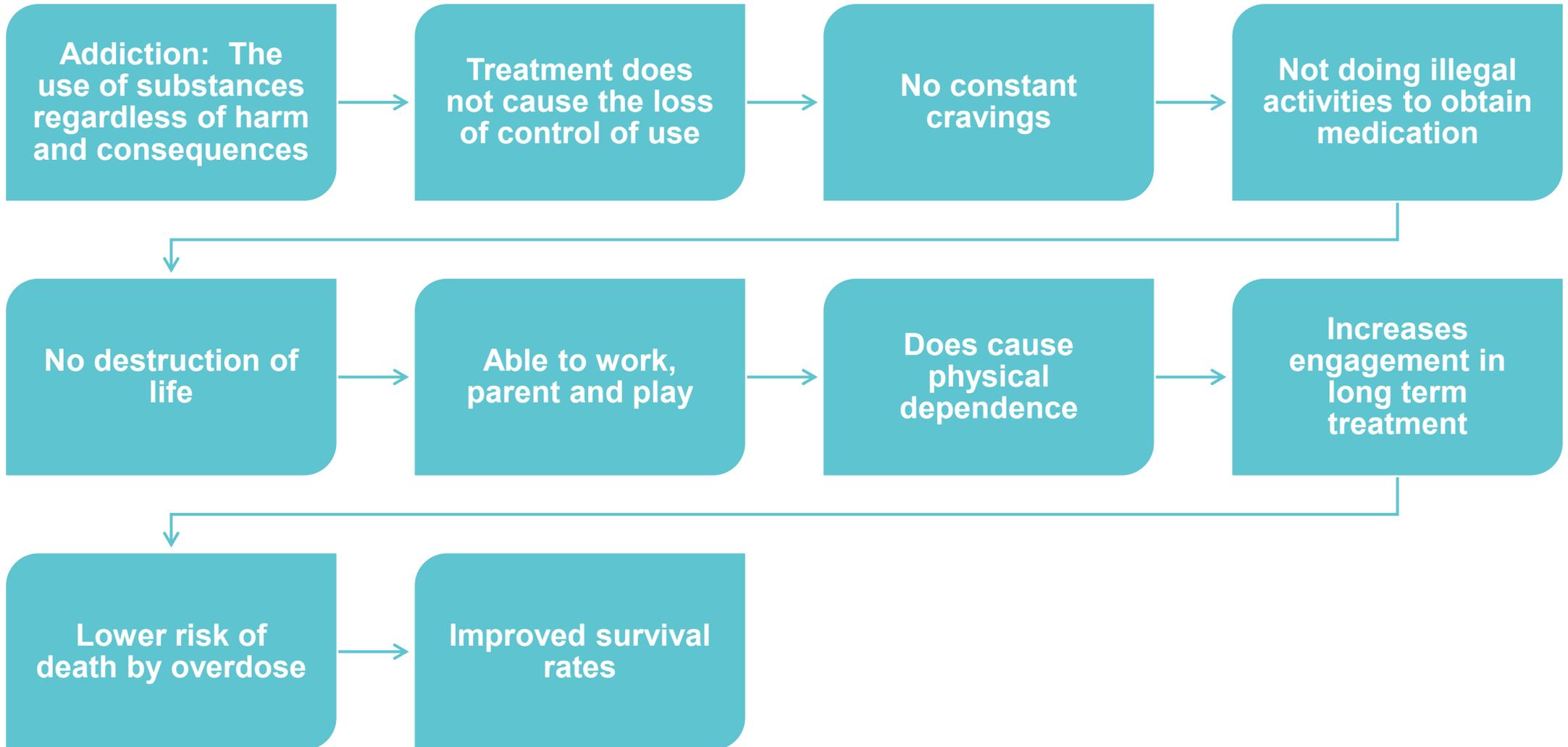
- Person has **not fully detoxed** from opioids (risk of precipitated withdrawal)
- History of **severe withdrawal symptoms** or trouble completing detox
- **Low internal motivation** or high risk of impulsive relapse
- Need for **ongoing or possible emergency pain management** (naltrexone blocks opioid pain meds)

The Less-Than-Ideal Candidate for Naltrexone Treatment

(continued)

- Struggles with **medication adherence** (for daily pill or follow-up for injection)
- Past **negative experience** with naltrexone (e.g., emotional blunting or feeling unsupported)
- Client needs **symptom relief** from cravings or withdrawal

Trading One Addiction for Another?



Is MOUD Required for Recovery?

- Recovery doesn't come in a one-size-fits-all package. Some people use 12-step programs. Some use therapy, faith, community, or time. Some use medication. **All are valid.**
- MOUD is not about forcing a path—it's about **offering tools.**
- What the research tells us is this: people who use MOUD are more likely to **stay alive**, stay in treatment, and build a life in recovery.
- For some, MOUD is **temporary**. For others, it's **lifelong**. That's okay. We don't ask people to stop taking insulin after 90 days of good blood sugar.

Is MOUD Required for Recovery? *(continued)*

- The goal is not to be “off medication”—it’s to be **well**. To have **agency, health, and hope**.
- We should celebrate all pathways to recovery—and never shame someone for choosing the one that works.

Pregnancy and MOUD

- **MOUD is the standard of care** for pregnant people with opioid use disorder.
- **Methadone and buprenorphine** are both safe and effective during pregnancy.
- MOUD reduces the risk of **relapse, overdose, and fetal harm.**
- MOUD supports **prenatal care, bonding, and long-term stability.**

Pregnancy and MOUD *(continued)*

- Treatment reduces complications like **preterm birth and low birth weight**.
- Staying on MOUD during pregnancy is often **safer than tapering off**.

Breastfeeding and MOUD

- **Breastfeeding is safe** with methadone and buprenorphine.
- **Very small amounts** of medication pass into breast milk.
- Breastfeeding may **reduce the severity of neonatal withdrawal (NOWS)**.
- MOUD supports **bonding, maternal confidence, and infant development**.

Breastfeeding and MOUD *(continued)*

- MOUD is encouraged by **AAP, ACOG, and SAMHSA** when other health factors are stable.
- Naltrexone: There is **limited data** in breastfeeding—use caution.

When to taper?

When to taper?

When the client is ready.

Common Myths



Key Takeaways – MOUD at a Glance

MOUD saves lives—reduces overdose and improves recovery outcomes.

Three FDA-approved options: methadone, buprenorphine, naltrexone.

Matching the medication to the person is critical for success.

Stigma is still a major barrier—language and attitude matter.

MOUD is safe during pregnancy and breastfeeding.

Recovery is **individualized**—MOUD is one path, not the only path.

Compassionate, evidence-based care **changes everything.**

Resources - Books

- *Dreamland: The True Tale of America's Opiate Epidemic* — Sam Quinones — Bloomsbury Press
- *Canary in the Coal Mine* — William Cooke, MD (with Laura Ungar) — Tyndale Momentum
- *The Many Lives of Mama Love* — Lara Love Hardin — Simon & Schuster
- *Chasing the Scream: The First and Last Days of the War on Drugs* — Johann Hari — Bloomsbury Publishing
- *The Heroin Diaries* — Nikki Sixx — MTV Books / Pocket Books
- *Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference* — Stephen Trzeciak & Anthony Mazzeo — Studer Group
- *Toxic Charity: How Churches and Charities Hurt Those They Help (And How to Reverse It)* — Robert D. Lupton — HarperOne
- *Demon Copperhead* — Barbara Kingsolver — Harper
- *In the Realm of Hungry Ghosts: Close Encounters with Addiction* — Gabor Maté, MD — North Atlantic Books
- *Dopesick: Dealers, Doctors, and the Drug Company that Addicted America* — Beth Macy — Little, Brown and Company

Thank you and Questions



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You have completed the course:
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Thank you!