

HCS Media Backgrounder: Medications for Opioid Use Disorder

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BACKGROUND: MEDICATIONS FOR OPIOID USE DISORDER

Studies show that people with opioid use disorder who stop taking opioids, even under the guidance of a health care provider, are very likely to return to using the drug (relapse). Relapse is common. It is best to consider it as a learning opportunity, rather than focus on relapse as a failure. Relapse can be life threatening due to the elevated/significant risk for fatal overdose.

There are three FDA-approved medications that can lower the risk of relapse and overdose. These medications improve a person with opioid use disorder's function, productivity, and participation in other treatment. These medications include methadone, buprenorphine, and naltrexone.

Evidence shows that these medications:

- reduce opioid use and opioid use disorder-related symptoms;
- in some cases, increase the likelihood they will stay in treatment;
- reduce criminal behavior associated with drug use and reduce criminal justice involvement;
- reduce the risk of infectious disease, including HIV and HCV transmission;
- increase likelihood of employment; and
- block the respiratory depressant effects of other opioids that can cause overdose death.

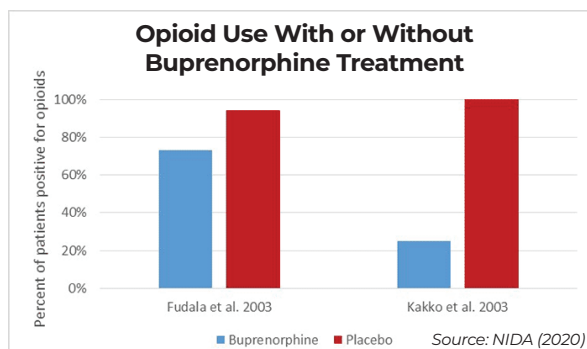
Methadone is a long-acting opioid agonist, meaning it activates opioid receptors in the brain—the same receptors activated by opioids such as heroin, morphine, and opioid analgesic pain medications. It helps to eliminate withdrawal symptoms and

relieves opioid cravings. Methadone has been used successfully for more than 50 years. Federal and state regulations require that patients go in person to a clinic regularly for dosing, although the onset of the COVID-19 pandemic has allowed for some flexibility in how people receive methadone. It can be started before a person completes the opioid withdrawal process, and the treatment doses should not produce euphoria/sedation.

Buprenorphine is a long-acting partial opioid agonist, meaning that it binds to those same opioid receptors but cannot produce as strong a maximal effect as methadone. Buprenorphine also reduces cravings for opioids and withdrawal symptoms without producing euphoria and can be prescribed by certified health care providers in a

doctor's office. Research has found buprenorphine to be similarly effective as methadone for treating opioid use disorders and can be started before a person completes withdrawal.

Naltrexone is an opioid antagonist, which means that it works by blocking the activation of opioid receptors and by preventing any opioid drug from producing the "high." Since 2010, naltrexone has been available in an injectable, long-acting form originally approved for alcohol use disorders. It is a good option for patients who do not have ready access to health care or who struggle with taking their medications regularly. However, the patient must fully stop using opioids for 5-7 days (or longer) before treatment can begin, and that can be an obstacle for some people.



Research shows that buprenorphine is more effective than treatment without medication, and that overdose deaths were higher among those who were tapered off buprenorphine despite having access to counseling services.

REFERENCES

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