LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

Medication for Opioid Use Disorder
MYTHS & FACTS

Medication for opioid use disorder (MOUD) is the evidence-based, standard of care treatment for opioid use disorder (OUD).[1] MOUD is often used in combination with counseling and behavioral therapies to provide a whole-patient approach to treatment. Methadone, buprenorphine, and injectable naltrexone are the three Food and Drug Administration (FDA) approved medications to treat OUD. They stabilize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and improve physical and mental health. Numerous studies have shown that MOUD reduces illicit opioid use, the risks of overdose and death, disease rates, and criminal legal involvement.[2] Despite overwhelming evidence of MOUD's benefits, many people view it negatively. They prohibit treatment with MOUD, even when clinically appropriate.

The following are common myths and facts about MOUD. Relying on the facts will increase the chance that people enter and sustain recovery.

MYTH	FACT
Treatment with MOUD "substitutes one addiction for another."	**When used as prescribed, addiction medications stabilize brain chemistry and reduce cravings, thereby preventing illicit use of opioids without causing a "high."**[3] The misconception that buprenorphine and methadone substitute one addiction for another is scientifically inaccurate and undermines effective OUD treatment. The myth is thought to be true because buprenorphine and methadone are opioids. However, while heroin, oxycodone, and other substances that often lead to OUD are short-acting and create euphoria, buprenorphine and methadone are long-acting medications. These medications are designed to treat symptoms of addiction, such as cravings and withdrawal, without leading to compulsive illicit opioid use or euphoria.[4]

(This myth is not often associated with injectable naltrexone, because that medication is not opioid based.)

MYTH	FACT
Addiction medications are a "crutch" that prevent "true recovery."	**It is well-accepted that treatment with MOUD is the central component of successful long-term recovery for many people with OUD.** Recovery is "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."[5] By stabilizing brain chemistry, relieving withdrawal, and stemming cravings, MOUD also provides space to work on other aspects of recovery. Importantly, MOUD is beneficial on its own.[6] Evidence shows that treatment with just methadone or buprenorphine is more beneficial than counseling and supportive services with or without medication.[7]

MYTH	FACT
MOUD should not be long-term.	**The length of treatment with MOUD is a decision that should be made by an individual in treatment in conjunction with their clinician. There is no one-size-fits-all duration for MOUD.** The Substance Abuse and Mental Health Services Administration ("SAMHSA") treatment protocols advise against "arbitrary time limits on the duration of treatment with OUD medication."[8] Instead, individuals in treatment should continue to take methadone and buprenorphine for the amount of time they want to, unless there is a medical reason to change their course of treatment.[9] Evidence shows that tapering or discontinuing medication leads to very high rates of relapse, and that the "best results occur when a patient receives medication for as long as it provides a benefit."[10]

MYTH	FACT
Requiring people to taper off MOUD helps them get healthy faster.	**Requiring people to stop taking their addiction medications is counter-productive and increases the risk of relapse.**[11] Decisions about MOUD treatment should come from an individual and their clinician. SAMSHA explains that "forcing a patient to taper off of medication for nonmedical reasons or because of ongoing substance misuse is generally inappropriate."[12] If someone in treatment is forced to stop or taper their methadone or buprenorphine, they will often experience the symptoms of OUD, including cravings. Their tolerance to opioids also will decrease, which means that if they resume illicit opioid use, they are at greatly increased risk of relapse that could result in a life-threatening or deadly overdose.[13]

MYTH	FACT
Stopping MOUD and later resuming it is a sign that MOUD is not effective.	**OUD is a chronic brain disease that leads to significant changes in brain structure and function.[14] These changes to the brain can persist for many years, even after stopping illicit opioid use.[15]** MOUD stabilizes changes to the brain caused by OUD and stem symptoms like cravings, but does not permanently reverse these changes. Therefore, people who discontinue medications – by choice or by force – often have recurrent symptoms, like cravings or withdrawal, and may need to restart medication treatment. Resuming MOUD is not a sign of failed treatment or moral weakness, but rather a sign of a patient's commitment to recovery. Restarting medication after a period of discontinuation is common among patients with OUD and encouraged by professional guidelines.[16]

MYTH	FACT
Courts are in a better position than doctors to decide appropriate OUD treatment.	**As with other chronic medical disorders, decisions about OUD treatment should be tailored to an individual's needs and based on shared decision making between the individual and their clinician.[17]** Just as judges, probation officers, employers, and family court practitioners would not decide that a person should treat their diabetes through exercise and diet alone and instruct them to stop taking insulin, these same actors are not trained to make medical decisions with respect to MOUD.

MYTH	FACT
People should stop treatment with MOUD if they have a positive drug test for illicit substances.	**Positive urine test results for illicit substances are not, in themselves, a clinical rationale for discontinuing MOUD.** Illicit opioid use while in treatment with MOUD may actually suggest that the prescribed dose is inadequate and should be increased.[18] The use of non-opioid substances is not a sign of MOUD treatment failure, because MOUD effectively treats only OUD – not other substance use disorders. A positive drug test for other substances may be a sign that the individual needs additional supports tailored to those substances. Programs that routinely discontinue treatment for positive urine screens are not following the standard of care.[19]

MYTH	FACT
Because MOUD is sometimes bought and sold on the "back market," it should be banned in the criminal legal and family court systems.	**The fact that some people may buy and sell MOUD on the black market neither negates the effectiveness of MOUD nor means that people are using non-prescribed MOUD for a "high."** In fact, research suggests the opposite: the great majority of people who use MOUD without a prescription are not doing so to achieve a high, but rather as self-treatment to avoid withdrawal, to stop using other opioids, or because they can not afford drug treatment.[20] Research has also demonstrated that using non-prescribed MOUD is a predictor of seeking treatment.[21]

[1]MOUD is also referred to as medication-assisted treatment or MAT.
[2] National Academies of Science, Engineering, and Medicine, *Medications for Opioid Use Disorder Saves Lives*, at 38-39 (2019), https://www.nap.edu/catalog/25310/medications-for-opioid-use-disorder-save-lives (last visited Mar. 25, 2021); National Institute of Drug Abuse ("NIDA"), *Effective Treatments for Opioid Addiction* (Nov. 2016),
[3] NIDA, *supra* note 2.
[4] Thomas R. Kosten & Tony P. George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, 1 SCIENCE & PRACTICE PERSPECTIVE 13, 18 (2002).
[5] NIDA, *surpa* note 2, at 26.
[6] *Id*. at 48.
[7] *See e.g*., Sarah E. Wakeman et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder*, *3* JAMA NETWORK OPEN 1, 8 (2020); Valerie A. Gruber et al., *A Randomized Trial of 6-Month Methadone Maintenance With Standard or Minimal Counseling versus 21-day Methadone Detoxification*, 94 Drug and Alcohol Dependence 199, 203 (2008).
[8] *See* Substance Abuse and Mental Health Services Administration ("SAMHSA"), *Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families*, 1-8 (2018), https://www.ncbi.nlm.nih.gov/books/NBK535268/pdf/Bookshelf_NBK535268.pdf (last visited Apr. 19, 2021).
[9] *Id*. at 3-31; 3-67; 3-68.
[10] *Id*. at 1-8.
[11] *Id*.
[12] *Id*. at 3-88.
[13] NIDA, *supra* note 2, at 23.
[14] *Id*. at 2.
[15] Alan I. Leshner, *Addiction is a Brain Disease, and it Matters*, 278 SCIENCE 45, 46 (1997); Nora D. Volkow et al., *Neurobiologic Advances from the Brain Disease Model of Addiction*, 374 NEW ENGLAND JOURNAL OF MEDICINE 363, 366 (2016).
[16] American Society of Addiction Medicine ("ASAM"), *National Practice Guidelines for the Treatment of Opioid Use Disorder, 2020 Focused Updated* at 43, available at https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2 (last visited Mar. 25, 2021).
[17] *Id*. at 27.
[18] Richard P. Mattick et al., *Buprenorphine Maintenance Versus Placebo or Methadone Maintenance for Opioid Dependence*, COCHRANE DATABASE SYSTEMATIC REVIEW, at 16 (2004)
[19] ASAM, *National Practice Guidelines*, *supra* note 16, at 4.
[20] Zev Schuman-Oliver, et al., *Self-Treatment: Illicit Buprenorphine Use by Opioid-Dependent Treatment Seekers*, 39 J. Substance Abuse Treatment 41, 48 (2010); Alexander R. Bazazi et al., *Illicit Use of Buprenorphine/Naloxone Among Injecting and Noninjecting Opioid Users*, 5 J. Addiction Med. 175, 178 (2011); *accord* Becky L. Genberg et al., *Prevalence and Correlates of Street-Obtained Buprenorphine Use Among Current and Former Injectors in Baltimore, MD*, 38 Addict Behav. 2868, 2871 (2013).
[21] Jennifer J. Carroll et al., *The More Things Change: Buprenorphine/Naloxone Diversion Continues While Treatment Remains Inaccessible*, 12 J. Addiction Med. 459, 461 (2018).