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EXPLAINER

People With an Opioid Use Disorder Need Treatment Options

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Millions of Americans are living with an opioid use disorder (OUD), and despite recent progress fighting the overdose crisis, tens of thousands still die annually. The harms of OUD extend beyond the individual: Over 40 percent of Americans report knowing someone who died of an overdose, and the health, productivity, and criminal justice consequences cost communities almost $1 trillion annually. Medications for opioid use disorder (MOUD) are the safest, most effective, and most preferred treatment approach, but they are not one-size-fits-all, and each has distinct benefits and drawbacks. To optimize treatment outcomes and the subsequent benefits to society, people struggling with an OUD must be able to choose the right medication for them with assistance from their healthcare provider.

How do MOUD work?

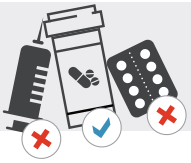
The Food and Drug Administration (FDA) has approved three medications for the treatment of OUD: methadone, buprenorphine, and naltrexone. Each of these medications interacts with the body differently to reduce physical cravings for other opioids, prevent other opioids from producing rewarding effects, and lower the likelihood of illicit opioid use.

MOUD work by interacting with receptors on the surface of cells. All three bind to the μ-opioid receptor and block other opioids from binding and interacting with it. Where the medications differ is in their ability to activate the μ-opioid receptor, which is why each MOUD has different side effects, effectiveness, and initiation procedures. These differences are summarized in the following table.

Treatment Properties	Naltrexone	Buprenorphine	Methadone
Activates μ-opioid receptors?	No (Antagonist)	Partially: 50-70 percent (Partial agonist)	Fully (Full agonist)
Stops other opioids from binding?	Yes	Yes	Yes
Maintains tolerance?	No	Yes	Yes
Causes dependence?	No	Yes	Yes
Causes respiratory depression?	No	Limited	Yes
Causes severe withdrawal if initiated while still using?	Yes	Yes	No
Requires abstinence to initiate?	Yes (7+ days)	Yes (12-24 hours)	No
Reduces overdose risk from other opioids?	No	Yes (up to 80 percent)	Yes (up to 80 percent)
Able to cause an overdose itself?	No	Possible, but extremely unlikely	Yes (especially during early initiation stages)
Produces euphoria or rewarding effects?	No	Not when taken as prescribed; limited even at high doses	Not when taken as prescribed
Causes withdrawal if abruptly stopped?	No	Yes	Yes

Why is patient medication choice important for recovery?

These distinct mechanisms of action and effects on the body result in different experiences for the patient that shape recovery and associated outcomes. Ideally, healthcare providers and patients will assess treatment goals, personal preferences, and existing health status to decide which MOUD is most likely to benefit them. However, in practice, medication accessibility can influence MOUD choice.



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As the least restricted MOUD, naltrexone can be prescribed by any healthcare provider and is not subject to any special monitoring at the pharmacy level. Buprenorphine is slightly more restricted. Healthcare providers must complete a required minimum of eight hours of training on substance use disorders before they can prescribe Schedule II-V substances. While anyone who has done this training can prescribe buprenorphine, the weekly or monthly injectable formulations are more heavily restricted.

In addition, not all providers who can prescribe buprenorphine actually do so, and the number of prescribers varies significantly by geographic location. Filling prescriptions at pharmacies can also be challenging. Because buprenorphine is monitored as a controlled substance, high-volume dispensing can trigger an investigation. This dissuades some pharmacies from stocking the medication.

Methadone is the most restricted MOUD. When used for OUD, it is only accessible through specialized clinics called opioid treatment programs (OTPs). Because these clinics do not exist in the majority of counties, the average one-way drive time to an OTP is 37 minutes (49 minutes in rural areas). This can discourage patients from using methadone because they must visit an OTP in person up to six days per week to take their medication under direct supervision.

Certain policies can also inadvertently restrict consumer choice. Some states have policies that limit the maximum dose of methadone or buprenorphine that can be prescribed. Many state policies related to methadone prescribing are also more restrictive than federal guidelines, including limiting the ability to open new OTPs and restricting stable patients' access to take-home doses. Restrictive policies are often intended to prevent misuse and diversion of MOUD to the illicit market; however, diversion rates for methadone and commonly prescribed buprenorphine formulations are lower than those for prescription antibiotics.

While all approved MOUD improve treatment retention compared to non-medication treatment (such as cognitive behavioral therapy), they do so to different degrees. Methadone has the biggest positive impact on treatment retention, while naltrexone is associated with the smallest improvements. Some research shows that people who receive their preferred MOUD are less likely to use illicit opioids and have better treatment adherence.

OUD affects people from all walks of life, from single parents working multiple jobs to older adults managing an assortment of health issues. Consequently, choosing the appropriate medication requires considering the strengths and weaknesses of each medication in the context of a person's physical and psychological condition. It also means considering their schedule, co-occurring medical and psychiatric conditions, economic resources, and many other factors. Because each person's circumstances and needs are different, it is important that patients have access to the full spectrum of MOUD options to choose what is best for them.

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