Overview of Treatment Options for Opioid Use Disorder

Introduction

As treatment options for patients with opioid use disorder (OUD) expand, it's important to have a handy overview available to guide your conversations with patients. In this fact sheet, we cover the most evidence-based treatments and provide guidance for how to choose among them.

Medication for Opioid Use Disorder (MOUD)

Previously known as medication-assisted treatment (MAT), MOUD is the gold standard treatment, and the only approach convincingly shown to decrease opioid overdose mortality as well as all-cause mortality. MOUD also increases treatment retention, reduces opioid use, and mitigates harms associated with use. Of the three MOUD medications, methadone and buprenorphine have by far the most robust evidence base, though injectable naltrexone is catching up.

Methadone

- Methadone is a long-acting opioid agonist that reduces withdrawal symptoms and cravings. Its long half-life means that it can be taken once daily, and its slow time of onset means that it doesn't cause the intense euphoric effects of other opioids. It can only be dispensed through a federally licensed opioid treatment program (OTP), commonly called a "methadone clinic," when used to treat OUD.
- *Most appropriate use:* Consider methadone for patients who still experience opioid cravings on buprenorphine and those who could benefit from the structure of an OTP.
- *Usual treatment procedure:* Patients can start methadone in a hospital or ER setting but must enroll in a federally licensed OTP to continue treatment. Doses cannot exceed 40 mg over the first 24 hours and are gradually increased over the course of several weeks.
- *Continuing treatment:* Because methadone is a full agonist, it does not have a physiologic ceiling effect and can therefore be increased until the patient no longer has opioid cravings. That's usually around 90 mg, but some patients require much higher doses.

Buprenorphine

- Buprenorphine is a partial opioid agonist that can be prescribed in an office-based setting. It can be dispensed as sublingual films, sublingual tablets, or a long-acting injectable. Sublingual forms are often combined with naloxone in order to deter intravenous use.
- *Most appropriate use:* Buprenorphine is a good first-line treatment for most patients with OUD given its robust evidence base, ease of use, and better accessibility than methadone.
- *Usual treatment procedure:* Because of its partial agonism property, taking a dose of buprenorphine with opioid agonists in the system can cause precipitated withdrawal. Therefore, buprenorphine is usually started once the patient is in moderate withdrawal, and the dose is increased over a few days, a procedure called "induction."
- *Continuing treatment:* Buprenorphine can be increased by 8 mg each day, up to a total daily dose of 24 mg. Because buprenorphine is a partial agonist, few patients will derive benefit from going above this dose. If the patient is still experiencing cravings at 24 mg daily, consider switching to methadone.

Naltrexone

- Naltrexone is an opioid antagonist that blocks the effects of opioids and decreases cravings. While it is available as a pill, only the extended-release monthly injection (Vivitrol) has been shown to be effective for OUD.
- *Most appropriate use:* Naltrexone can be tricky to start, so it is best reserved for those who start their treatment in a supervised setting, either inpatient, a residential treatment program, or a jail/prison. Injectable naltrexone also can be a good option for the unhoused.
- *Usual treatment procedure:* Patients must be completely opioid free before the first dose of naltrexone is administered. For most opioids, that means at least a week, but it can take longer if the patient is taking a long-acting opioid like methadone. If there is any doubt, a naloxone challenge test can let you know if a patient is ready for naltrexone.
- *Continuing treatment:* Injectable naltrexone is meant to be administered once every four weeks; however, this interval tends to be a bit long for some patients. You can give it at intervals as short as three weeks if your patient starts to develop drug cravings early.

Psychotherapy

Data have not shown psychosocial interventions to be an effective stand-alone treatment for OUD. However, they can be helpful for many patients when combined with MOUD.

Cognitive behavioral therapy (CBT)

- CBT is a psychotherapy that helps individuals identify and change negative thought patterns and behaviors. It can be delivered in individual or group settings.
- *Most appropriate use:* Individuals who are willing and able to complete homework assignments; patients with generally good follow-up.
- *Usual treatment procedure:* The first several sessions typically involve reviewing the fundamentals of CBT theory. Subsequent sessions are spent identifying negative thoughts, examining them, and restructuring them so that they cause less distress. Patients complete homework assignments that are then reviewed in session.

Contingency management (CM)

- CM is a behavioral therapy that provides incentives (eg, vouchers or prizes) for individuals to remain drug free. The most evidence for CM is in patients with stimulant use disorders. It can be delivered in individual or group settings.
- *Most appropriate use:* Patients enrolled in large treatment centers with CM research studies or grants to support such programs; those with comorbid stimulant use disorders.
- *Usual treatment procedure:* The first session is spent reviewing the structure and rules of the CM program that the patient is enrolling in. Patients will be screened for recent substance use during each visit, typically with a urine drug screen, and may be given access to a reward depending on the screen's results.

Motivational interviewing (MI)

- MI is a therapeutic approach that focuses on each patient's personal reasons for not using substances. It can be delivered in individual or group settings.
- *Most appropriate use:* Any patient. MI can be used in brief settings, like an ER, or longitudinally with established patients. It is particularly useful for patients who are reluctant to engage in treatment.
- *Usual treatment procedure:* Early sessions consist of building therapeutic rapport and agreeing upon a change goal. In later sessions, the therapist explores and enhances the patient's own reasons for sobriety and helps the patient construct a change plan.