Treatment of Opioid Use Disorder

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What is medication treatment for opioid use disorder?

Opioid use disorder (OUD) is a treatable, often chronic medical condition. Medication for opioid use disorder (MOUD), historically called medication-assisted treatment (MAT)*, uses FDA-approved medications to reduce withdrawal symptoms and cravings, prevent return to uncontrolled opioid use, and reduce overdose and death. MOUD also reduces the risk for hepatitis C and HIV infection, crime, recidivism, sexually transmitted infections, healthcare costs, and societal costs.

Methadone, buprenorphine, and extended-release naltrexone are the three FDA-approved medications for OUD. They work differently, and treatment should be individualized to the patient's needs and preferences.

- Methadone: A long-acting, full opioid agonist. It activates opioid receptors in a controlled, sustained way, reducing withdrawal symptoms and cravings. For OUD, it is generally dispensed through a federally certified opioid treatment program (OTP).
- Buprenorphine: A partial opioid agonist. It activates opioid receptors enough to control withdrawal symptoms and cravings but has a ceiling effect on many opioid effects. It can be prescribed in office-based settings and, when appropriate, through telehealth. Available formulations include sublingual tablets or films and long-acting injections.
- Extended-release naltrexone: An opioid antagonist that blocks opioid receptors rather than activating them. Patients must first complete an adequate opioid-free period to avoid precipitated withdrawal, which can make starting treatment more difficult. Unfortunately, this does not generally treat the underlying addiction, and the FDA label warns of vulnerability to fatal overdose at the end of a dosing interval, after a missed dose, and after discontinuation — because opioid tolerance is reduced from baseline. Attempts to override the blockade with large opioid doses can also be fatal.

How does medication treatment such as methadone and buprenorphine save lives?

- Reduces overdose and death. Methadone and buprenorphine treatment are associated with lower all-cause and overdose mortality while patients remain in treatment.
- Controls withdrawal and cravings. Patients can stabilize their lives, reconnect with family, and pursue housing, employment, and other health care.
- Supports long-term recovery. Counseling, peer support, and other services can be valuable additions, but *medication is the foundation of effective treatment*.
- Reduces risk after an overdose. Starting medication and ensuring continuity of treatment after a nonfatal overdose can be lifesaving.

Why is buprenorphine different from other opioids?

Buprenorphine is a "partial opioid agonist," meaning its effects on opioid receptors reach a ceiling over a range of doses. This creates a ceiling effect on respiratory depression, making severe respiratory depression less likely than with full opioid agonists when buprenorphine is taken.

This is a relative safety advantage, not complete protection. Overdose and respiratory depression can still occur, particularly when buprenorphine is combined with alcohol, benzodiazepines, or other sedatives. This underscores the need to not just treat the OUD.

Does diversion of buprenorphine increase or decrease harm?

Some prescribed buprenorphine is used outside the directions of the prescription or obtained without a prescription. Research and clinical experience suggest that people often use diverted buprenorphine to relieve withdrawal symptoms and cravings when they cannot access formal treatment.

Diversion may actually reduce harm when it helps people avoid illicit opioids and manage withdrawal. It should not automatically be equated with recreational misuse. Diversion is not risk-free, particularly for children, and appropriate safeguards remain important. However, overly restrictive prescribing and dispensing practices can make treatment harder to obtain and may increase exposure to illicit opioids.

What is NOT a recommended treatment for OUD?

- Cannabis: Not an evidence-based treatment for OUD and should not replace medication treatment.
- Kratom, including concentrated 7-hydroxymitragynine (7-OH) products: Not FDA-approved or recommended as treatment for OUD. Products can have variable potency and can cause dependence and withdrawal.
- Therapy alone: Counseling can help, but it is not an adequate substitute for medication for many people with OUD. Requiring therapy before medication can delay lifesaving care.
- Psilocybin: Not FDA-approved or recommended as treatment for OUD. Products can have variable potency and other risks, and are not yet considered the standard of care.

Barriers to treatment and opportunities for legislative action

Why do people still struggle to obtain treatment that works?

1. Persistent myths and stigma

The claim that MOUD is simply "substituting one drug for another" mistakenly conflates medical treatment with uncontrolled substance use. Methadone and buprenorphine treat a medical condition, reduce cravings and withdrawal, and lower the risk of death.

2. Unnecessary treatment requirements

Some programs require counseling, group therapy, or abstinence from alcohol and other drugs before initiating or continuing medication. Others discharge patients after a return to substance use.

These practices can interrupt effective treatment. Care should be individualized, nonpunitive, and very low-barrier. Counseling should be offered when helpful, not imposed as a prerequisite for medication.

3. Underestimating the duration of treatment

OUD is generally a chronic condition. Many people need treatment for years, and some benefit from lifelong medication.

Treatment lasting 18–24 months or longer is common. Decisions about tapering should be individualized and patient-led. *Stopping medication prematurely can increase the risk of return to opioid use and fatal overdose.*

4. Pharmacy-related barriers

Patients may encounter pharmacies that:

- Do not stock buprenorphine or cannot provide it promptly.
- Delay or refuse to fill prescriptions without a clear clinical or legal basis.
- Decline prescriptions from telehealth clinicians.
- Impose geographic restrictions, including reported policies refusing prescriptions from clinicians located more than 5 miles away.
- Apply inconsistent or overly restrictive dispensing practices because of stigma, uncertainty, or fear of regulatory scrutiny.

Prescriber availability alone does not ensure access if patients cannot fill their prescriptions.

5. Fear of litigation or regulatory scrutiny

New Mexican clinicians and health systems often fear complaints, investigations, or lawsuits. Uncertainty can discourage clinicians from offering treatment even when it is medically indicated.

6. Co-occurring substance use and mental health conditions

People with OUD often also have stimulant use disorder, serious mental illness, trauma, chronic pain, or other complex needs. There is a critical shortage of mental health care in New Mexico, and existing programs are often not equipped to treat these conditions together.

Stimulant use disorder is not uncommon alongside OUD (eg., methamphetamine use, cocaine use, etc). Contingency management (providing financial incentives for abstinence from a stimulant) is the gold standard for treatment, and is largely unavailable in New Mexico.

7. Treatment programs and clinical settings that do not offer medication

Many residential, correctional, and community treatment programs still do not offer all evidence-based OUD medications – and some require patients to discontinue them.

People should not have to choose between entering a treatment program and continuing medication that keeps them alive. Publicly funded and licensed programs should offer medication or reliably arrange access to it, and reporting mechanisms for percentage of medication uptake.

A study in 2021 identified that only about half of hospitals in New Mexico had buprenorphine available. This is believed to be improved, but is concerning.

8. Homelessness and other practical barriers

People experiencing homelessness need treatment where they are: shelters, mobile clinics, outreach settings, emergency departments, and community sites. Transportation, medication storage, identification requirements, insurance interruptions, and lack of follow-up can all interfere with care.

Jails and prisons: continuity of treatment saves lives

The period immediately after release from incarceration is particularly dangerous because opioid tolerance may decline while overdose risk remains high.

Effective policy should ensure that correctional systems:

- Continue methadone or buprenorphine when clinically indicated rather than forcing withdrawal.
- Offer medication initiation to people who want treatment.
- Arrange a medication bridge or coordinated opioid treatment program access at release.
- Schedule an outpatient appointment and provide a direct handoff to community care.
- Coordinate insurance, transportation, and relevant clinical information.
- Provide naloxone and overdose prevention education at release.
    - A prescription is insufficient, as a 2021 study found that only about 78% of pharmacies in Albuquerque had naloxone. Data from 2024-2025 showed about a quarter of pharmacies in Santa Fe were not filling buprenorphine.

A referral slip alone is not continuity of care.

Practical priorities for New Mexico

1. Protect access to evidence-based medication. Support coverage and reimbursement for methadone and buprenorphine, including appropriate same-day initiation and long-acting formulations (shots). Pilot targeted enhanced reimbursement for clinics providing MOUD care, tax credits, and/or loan repayment.
2. Reduce arbitrary barriers. Address pharmacy dispensing barriers and ensure that telehealth-based treatment is not subject to unjustified restrictions.
3. Require meaningful access in treatment programs. Publicly funded and licensed programs should offer or reliably arrange MOUD without abstinence or counseling prerequisites.
4. Prioritize continuity in correctional settings. Support starting and continuing treatment during incarceration and include direct linkage to outpatient care upon release.
5. Expand low-barrier treatment. Support mobile services, telehealth, outreach, and treatment for people experiencing homelessness.
6. Integrate care. Improve access to mental health treatment and services for co-occurring substance use disorders – particularly contingency management for stimulant use disorder and psychiatric care for severe mental illness.
7. Support clinicians and pharmacists. Provide clear, evidence-aligned guidance and education to reduce stigma and fear-driven barriers related to malpractice risk.
8. Expand overdose prevention. Fund naloxone distribution, peer support, and coordinated follow-up after overdose or incarceration.