



Medications in Recovery

MAT, MOUD, myths, and the facts · Recovery in Focus · Session Packet

There are medications, approved, studied for decades, and prescribed by doctors, that treat addiction itself. Clinicians call the approach **MAT** (medication-assisted treatment) or, for opioids specifically, **MOUD** (medications for opioid use disorder). The main ones: **buprenorphine** (Suboxone), which steadies the opioid system without the high and blocks other opioids; **methadone**, the oldest and most-studied, dispensed through clinics; **naltrexone** (Vivitrol), a blocker with no opioid effect at all, also used for alcohol; and for alcohol, **acamprosate** and **disulfiram**. Different tools, one job: quieting the biological storm, craving, withdrawal, the 2 a.m. pull, so the person can actually do the rest of recovery.

And yet no treatment in this field drags more judgment behind it. "You're just trading one drug for another." "You're not really clean." People have heard it from family, from meetings, sometimes from the mirror. So let's put the headline fact on the table in the first paragraph, because it deserves the front page: for people with opioid use disorder, being on methadone or buprenorphine **cuts the risk of death roughly in half**. Not improves mood, not eases withdrawal: cuts death in half. There are very few things in all of medicine that do that. This session is about what these medications actually do, what the myths get wrong, and how to think about them for yourself or stand beside someone who uses them, without shame in either direction.

What is in this session?

This session has four parts, usually covered over two group meetings:

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|----------------|----------------------------|------------------------|
| CLASS 1 | 1. What the Medications Do | 2. The Myths, Examined |
| CLASS 2 | 3. Stigma and the Rooms | 4. Making It Personal |

After this session you will be able to

- Explain what buprenorphine, methadone, and naltrexone each do, in plain words
- Answer the "trading one drug for another" myth with the actual pharmacology
- Handle medication stigma, from others and from inside yourself
- Know the questions to ask a prescriber, for yourself or someone you love

What will be asked of you?

You'll be asked to examine beliefs you may have held for years, some learned in the rooms, some at kitchen tables. Nobody here will push medication on anyone; that decision belongs to each person and their doctor. What this group does is retire the misinformation, because people have died of the myths.

Part 1: What the Medications Do

WAIT, REALLY?

Decades of studies agree: people with opioid use disorder on methadone or buprenorphine die at **roughly half the rate** of those not on medication. If any pill cut heart-attack deaths in half, refusing to mention it would be malpractice.

How they work, kitchen-table version: an opioid-trained brain has a broken thermostat: it screams for opioids to feel normal. **Methadone** and **buprenorphine** set the thermostat to steady: taken as prescribed, at stable doses, they don't deliver a high; they deliver normal, which is why people on them hold jobs, raise kids, and drive to work like anyone on blood-pressure medication. Buprenorphine has a ceiling (more doesn't mean more effect) and blocks other opioids on top. **Naltrexone** is the opposite approach: no opioid action at all, just a blocker, so using through it does nothing; it requires full detox first, and it also blunts alcohol craving. For alcohol, **acamprosate** quiets post-acute craving and **disulfiram** makes drinking physically miserable, a fence some people choose to build.

EXERCISE 1

Answer yes or no:

1. Before today I could have explained the difference between methadone, buprenorphine, and naltrexone. ☐ Yes ☐ No
2. I knew the death-rate fact before this page. ☐ Yes ☐ No
3. Someone I know is alive today, or might have been, because of these medications. ☐ Yes ☐ No

EXERCISE 2

In your own words, no jargon: what's the difference between a drug that gets you high and a medication that gets you to normal?

Part 2: The Myths, Examined

Take the big three apart, one at a time:

- **"Trading one drug for another."** The trade is real; the question is what's being traded. Chaos for stability. A \$200-a-day habit with fentanyl roulette for a prescribed dose with a doctor's name on it. Highs and withdrawals for a flat normal. By that logic insulin is "trading" too. The addiction was never about a molecule being present; it was craving, loss of control, and a life coming apart. Medication at stable doses produces none of those.
- **"You're not really clean."** "Clean" was always a loaded word; recovery is measured in a life, not a urine panel. The person back at work, present for their kids, done with the chaos, is in recovery by any measure that matters. Medication status is medical information, like anyone's prescriptions.
- **"It's the easy way out."** Ask anyone who's stood in a methadone line at 5:30 a.m. before work for three years. Medication removes the biological screaming; it doesn't do the amends, the honesty, the rebuilt trust, the meetings, or the years. It makes the work possible. It doesn't do the work.

EXERCISE 3: MYTH AUDIT

Check any you've believed, said, or heard said to someone:

- | | |
|--|--|
| ☐ "Trading one drug for another" | ☐ "You'll be on it forever" (said like a verdict) |
| ☐ "Not really clean / not really sober" | ☐ "Real recovery doesn't need pills" |
| ☐ "The easy way out" | ☐ Other: _____ |

Where I learned the one I believed hardest: _____

EXERCISE 4

Pick one myth and write the two-sentence answer you'd give it now:

End of Class 1. Talk it out:

- Which myth lived in your head, and who put it there?
- What changes if "recovery" is measured in a life instead of a urine panel?

Part 3: Stigma and the Rooms

Here's the tension nobody should have to navigate alone: the mutual-help world saves lives, and parts of it have been slow on medication. Some meetings welcome everyone; some have rules about who can share or hold service positions; some members push their personal opinions onto newcomers as if they were rules. People have quit life-saving medication to satisfy a sponsor and died of it. So the practical guidance: your medication status is yours to share or not; "I'm in recovery" is a complete sentence. There are meetings and fellowships explicitly friendly to medication, and a sponsor who plays doctor is a sponsor giving advice outside their lane, no matter how much clean time they have. The same filter applies at kitchen tables: family members repeating myths usually learned them the same place you did.

EXERCISE 5

Answer yes or no:

1. I've heard medication judged inside a meeting or program. ☐ Yes ☐ No
2. I've judged someone's recovery because of their medication. ☐ Yes ☐ No
3. I'd know what to say now if someone told me I'm "not really sober." ☐ Yes ☐ No

Rosa

Rosa has fourteen months on buprenorphine: working, custody back, Sunday dinners again. At a meeting, a man with long clean time tells her she can't take a chip because she's "still using." She goes home and stares at her prescription bottle for a long time. Her doctor's words win by one sentence: "This medication is why you've had fourteen months to build all that." She finds a different meeting across town where three other people are on the same medication. She keeps the doctor, keeps the medication, keeps the Sunday dinners. The man at the old meeting still has his opinion. Rosa has her life.

EXERCISE 6

1. What was the man's error, and what was it going to cost Rosa?

2. What saved her: the doctor's sentence, or the second meeting? Why both?

3. Write the one-sentence answer Rosa could carry for next time:

Part 4: Making It Personal

Three situations, three moves. **If medication might be for you:** that's a conversation with a prescriber, not a group vote; this program can route you today, and the questions worth bringing: which option fits my history, what does starting look like, what's the plan for how long, what happens if I slip. **If you're on it now:** as prescribed is the whole deal, same as any medication; the dose decisions belong to you and the doctor, never to a sponsor, a partner, or a bad week; and any pressure you're getting to quit it belongs in this room and your counselor's office, out loud. **If it's not for you:** good, that's a valid lane too, and your job is the same as everyone's: never repeat the myths at someone else's kitchen table. Half the deaths from stigma come from loved ones repeating it sincerely.

EXERCISE 7: MY LANE

My situation (considering it / on it / not for me / supporting someone on it):

The next step in my lane, specifically: _____

The myth I'm personally retiring, and who gets to hear me retire it:

EXERCISE 8

Someone you care about tells you they're starting Suboxone and they're ashamed. Write what you say:

SKILL OF THE DAY: RETIRE ONE MYTH OUT LOUD

Once this week, when medication comes up, in a meeting, at a table, in your own head, answer the myth with one plain fact. "It cuts death in half" is enough. Stigma dies one corrected sentence at a time.

Take it to the group

- What would change in our community if the death-rate fact were as famous as the myths?
- Where's the line between a sponsor's guidance and a sponsor playing doctor?
- What do you owe somebody on medication who's doing the work? What do they owe anybody?
- Rosa kept the doctor and changed the meeting. When is changing the room the recovery move?

Session summary

Medications for addiction treat the biological storm so the human work of recovery can happen, and for opioid use disorder they cut death roughly in half. The myths, trading, not-really-clean, easy way out, don't survive contact with the pharmacology or the lives. This session you examined where your own beliefs came from, learned the plain-words facts, practiced answering stigma including inside the rooms, and picked your lane with a next step.

Words used in this session

- **MAT / MOUD:** medication-assisted treatment; medications for opioid use disorder.
- **Buprenorphine (Suboxone):** steadies the opioid system without a high at stable doses; ceiling effect; blocks other opioids.
- **Methadone:** the oldest, most-studied option; full agonist at controlled clinic doses; decades of mortality evidence.
- **Naltrexone (Vivitrol):** pure blocker, no opioid effect; requires detox first; also blunts alcohol craving.
- **Stable dose:** the point where medication delivers normal, not high. The entire difference between treatment and trading.

Takeaway: The medication does the chemistry; the person still does the recovery. Measure people by their lives, keep dose decisions between patients and doctors, and when the myth shows up at your table, answer it: it cuts death in half.
