A TREATMENT COURT CLINICIAN'S GUIDE

to Treating Participants Prescribed or Considering Medication to Treat Opioid Use Disorder

Contents

Introduction

This guide is for clinicians[1] working in treatment courts. It describes how treatment court clinicians can help a participant benefit from **medication for opioid use disorder (OUD)** (also known as MAT, which stands for medication in addiction treatment or medication-assisted treatment).

This guide was created by addiction medicine specialists with criminal justice expertise from the American Society of Addiction Medicine (ASAM) and treatment court professionals with addiction treatment expertise from All Rise (formerly the National Association of Drug Court Professionals). It reflects up-to-date, evidence-based information to support optimal outcomes for justice-involved individuals living with OUD.

Online readers will find links to the resources referenced here embedded in the resource titles. Both print and online readers can also find all links listed in the resources section at the end of this guide.

Readers of this guide will understand:

- That medication for OUD saves lives.
- That individuals being treated for OUD while in any justice setting—including treatment courts, community supervision, prisons, and jails—should be quickly stabilized on pharmacotherapy (FDA-approved medications for OUD) and continue medication for OUD after their release to the community.
- The effectiveness of initiating and maintaining medication for OUD.
- How to communicate with treatment court colleagues regarding the utilization and effectiveness of medication for OUD.
- How to recognize opioid overdose and withdrawal and the importance of immediate medication treatment to prevent overdose and relieve withdrawal, as well as for OUD remission and long-term recovery.
- The importance of immediate and sustained treatment linkage in the community, as well as best practices and procedures to help support persons receiving medication for OUD to encourage retention.
- How to use quick tools to provide OUD screening.

[1] By "clinicians," we mean nonphysician professionals with clinical licensure or certification that allows them to diagnose and treat substance use and/or mental health disorders using psychosocial and other nonmedical treatment. Physicians working in treatment courts should reference *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder - 2020 Focused Update.*

Understanding Addiction and Medication for OUD

According to ASAM, addiction is a "treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases."

Brain changes in addiction lead to severe symptoms of withdrawal that can be debilitating and sometimes life-threatening. These changes result in the chronic compulsion to obtain opioids (or other drugs) to abate withdrawal symptoms.

Addiction reflects physiological change in the brain—not just behavioral patterns. Thus, it is crucial to understand that medications are often necessary to address the underlying changes in brain functions and improve outcomes. While psychosocial services are important, they do not prevent opioid withdrawal and may not be enough to prevent recurrence (also known as relapse) or death in those living with OUD.

- **Medications for OUD act by stabilizing brain function,** so the person no longer requires opioids to be stable. This enables them to benefit from psychosocial treatment and to focus on other areas of their life in ways that are not possible without the medication. There are multiple FDA-approved medications proven to decrease opioid use and prevent negative outcomes like death for persons with OUD. These medications should be continued as long as the person is deriving benefit. Arrest, incarceration, probation, or involvement in treatment court are not reasons to stop medication for OUD. Stopping these medications can quickly lead to opioid craving, recurrence, overdose, and death. Doing so against the wishes of the participant is also a likely violation of the Americans with Disabilities Act.
- **Medication for OUD treatment should not be interrupted when participants enter a treatment court setting or other part of the justice system.**
- **The immediate initiation and maintenance of medication for OUD can prevent recurrence and death, reduce criminal behavior, and otherwise enhance quality of life.**

Note: Adult treatment courts accept those at higher risk for treatment and supervision failure who are also classified as high need.

- High need is equated with those diagnosed with moderate to severe substance use disorder (SUD).
- The DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition) is the diagnostic manual used to diagnose persons with any severity of SUD—mild, moderate, or severe. The DSM-5 specifies that moderate SUD requires that 4 to 5 of the 11 criteria be met, and severe SUD requires 6 or more.[2] All of those diagnosed with severe SUD and many of those living with moderate SUD are living with addiction, the chronic, recurring form of SUD.
  - Summary of DSM-5's 11 criteria for SUD:
    - Opioids often taken in larger amounts or over a longer period than was intended
    - Unsuccessful efforts to cut down or control opioid use
    - Too much time spent in obtaining and using opioids
    - Cravings
    - Recurring opioid use that hinders obligations from work, school, or home
    - Continued opioid use, exacerbating social or interpersonal problems
    - Giving up social, occupational, and recreational activities for opioid use
    - Recurring use in physically hazardous situations
    - Continued opioid use despite use causing or worsening physical or psychological problems
    - Exhibits tolerance; needs more to achieve desired effect
    - Exhibits withdrawal

[2] For additional clarification, refer to the DSM-5.

TABLE 1. FDA-APPROVED MEDICATIONS TO TREAT OUD	
MEDICATION	**BRAND NAMES**
Buprenorphine	Sublocade™ (extended-release injection), generics
Buprenorphine and naloxone	Suboxone® (under-tongue film), Zubsolv® (tablets), Bunavail® (cheek film), generics
Methadone	Dolophine®, Methadose, generics
Extended-release naltrexone	Vivitrol® (injection)

Medications to Treat OUD

- **All FDA-approved medications for OUD should be available and accessible to individuals within the justice system. Treatment should be individualized.** (See *The ASAM National Practice Guideline for the Treatment of OUD, 2020 Focused Update*.)
- Buprenorphine and naltrexone for OUD can be prescribed in an office-based setting or opioid treatment program (OTP).
- Methadone can be dispensed only in an OTP.
- Buprenorphine and methadone can immediately treat opioid withdrawal in addition to preventing OUD recurrence and overdose.
- Buprenorphine and methadone can treat chronic pain disorders along with OUD.[3]
- Extended-release naltrexone can prevent OUD recurrence and overdose in persons who have not used opioids for at least seven days.

Benefits of Medication for OUD

FDA-approved treatments are **evidence-based and proven effective** in reducing opioid craving, recurrence, overdose, and death in persons with OUD. These medications:

- Reduce HIV and hepatitis C transmission and reduce other infections such as bloodstream infections and endocarditis (heart valve infection).
- Do not produce euphoria ("high") or sedation when appropriately dosed.
- Help participants feel normal, help them in their recovery, and prevent overdose.
- Do not substitute one addictive drug for another.
- Have specific actions on neurotransmitter receptors in the brain that lead to reduced cravings to use, shorten the length of any recurrences, and improve overall addiction and recovery outcomes.
- **Save lives by reducing the chance of overdose**.

[3] See *The ASAM National Practice Guideline for the Treatment of OUD, 2020 Focused Update* for full details.

- Significantly increase treatment entry and retention among individuals on probation and parole.
- Do not preclude any other ongoing psychosocial addiction treatment.

Successful OUD treatment, including medications, can increase participant recovery capital in multiple domains. Recovery capital is predictive of treatment outcomes and is described as the breadth and depth of all internal and external resources that can be brought to bear on the initiation and maintenance of SUD remission and recovery.

Medication for OUD and Treatment Courts

Some treatment court team members may be unaware of the benefits of medication for OUD. As clinicians, we have a duty to ensure that our clients have access to evidence-based treatments for OUD.

- Methadone, buprenorphine, and extended-release naltrexone are the most effective treatments available for OUD.
- Medication for OUD reduces opioid cravings, opioid use, overdose, and death.
- Medication for OUD supports courts' efforts to reduce recidivism.
- Medication for OUD should be **initiated as soon as possible**. That includes when individuals are in treatment court, pretrial, probation, jail, prison, parole, and reentry statuses.
- Treatment court clinicians are instrumental in linking participants to providers who can prescribe or dispense medications for OUDs, no matter where they are in the treatment court process.
- Individuals attempting to enter, progress through, or complete treatment court should not be forced to discontinue or be prevented from initiating medication for OUD.
  - It is a violation of citizen constitutional rights (Eighth Amendment) to not have access to medical care while incarcerated. Methadone can be dispensed only in regulated settings, such as OTPs. Some jails and prisons include medical units where methadone is dispensed.
    - OTPs are federally designated locations where persons with OUD can go to receive medication for treatment.
    - OTPs provide medication for OUD, including methadone, and counseling to participants with OUD. They are approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) and regulated at a federal level.
- **The duration of medication treatment should not be predetermined.** There is no recommended length of time for continuing medication for OUD. It is dependent on the severity of illness, outcome, response to treatment, and desires of the patient. Some patients will continue to benefit from medication for many years.
- Treatment courts should support the continued use of medication for OUD throughout the treatment court process.
- Treatment courts should facilitate access for medication for OUD.
- **Treatment courts should avoid using jail sanctions for participants prescribed medication for OUD unless the medication can be continued without interruption during incarceration.**
- **Incarceration is not an effective overdose prevention strategy. Even brief incarceration without medication for OUD increases the risk of overdose immediately after release.**

Screening for Initiation of Medication Treatment for OUD

Screening

- OUD screening is essential and does not require clinical expertise. Individuals with OUD are at risk for significant harm, and thus **all such persons should be screened for OUD and provided referral for initiation and maintenance of medication if positive**, even before placement in treatment court if necessary.
- The completion of an assessment or placement in treatment court should not delay medication for OUD treatment.
  - The 2020 ASAM guideline for the treatment of OUD states: "Comprehensive assessment of the patient is critical for treatment planning. **However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder.** If not completed before initiating treatment, assessments should be completed soon thereafter."
- Counseling and other behavioral interventions can be more effective after medication for OUD and medical treatment are initiated.
- **It is critical to alleviate any withdrawal symptoms and cravings first, then initiate psychosocial interventions after stabilizing the treatment court participant.**
- There may be times when psychosocial interventions begin before medication for OUD in the treatment court; however, psychosocial intervention should not replace medication for OUD.
- Treatment courts and settings where individuals are screened for treatment court eligibility should be able to immediately connect to qualified healthcare providers who can quickly initiate medication for OUD for individuals at risk for opioid withdrawal and to prevent recurrence and overdose.
- An opioid-positive urine drug screen is **not** necessary to initiate medication for OUD. **A quick and validated OUD screening tool** used in justice settings by both clinicians and nonclinicians is the **Rapid Opioid Dependency Screen (RODS).**

Following a positive RODS screen, the person can immediately be referred for final OUD diagnosis, assessment, and treatment by a doctor or other healthcare professional who can prescribe medication for OUD.

Diagnosis

- A doctor will verify a diagnosis of OUD before prescribing medication for OUD.
- Diagnosis and/or referral for evaluation are also conducted for any suspected mental health or medical disorders.
- All persons with signs or symptoms of medical discomfort that could indicate opioid withdrawal or any other medical problems, including diarrhea, vomiting, pain, etc., should be immediately referred for evaluation that could also include immediate treatment of opioid withdrawal. (See Table 4 for a list of withdrawal symptoms.)

TABLE 2. RAPID OPIOID DEPENDENCE SCREEN (RODS)		
1. Have you ever taken any of the following drugs:	Yes	No
Heroin		
Methadone		
Buprenorphine		
Morphine		
MS Contin		
Oxycontin		
Oxycodone		
Other opioid analgesics (e.g., Vicodin, Darvocet, Fentanyl, etc.)		
If no to all of the above, skip to the scoring instructions.		
2. Did you ever need to use more opioids to get the same high as when you first started using opioids?		
3. Did the idea of missing a fix (or dose) ever make you anxious or worried?		
4. In the morning, did you ever use opioids to keep from feeing "dope sick" or did you ever feel "dope sick"?		
5. Did you ever worry about your use of opioids?		
6. Did you ever find it difficult to stop or not use opioids?		
7. Did you ever need to spend a lot of time/energy on finding opioids or recover from feeling high?		
8. Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of opioids?		
Scoring instructions: Add the number of "yes" responses for Questions 2 to 8. If the total answer is ≥3, the RODS screen is positive.		

Adapted from Wickersham, J. A., Azar, M. M., Cannon, C. M., Altice, F. L., & Springer, S. A. Validation of a brief measure of opioid dependence: The Rapid Opioid Dependence Screen (RODS). Journal of Correctional Health Care, 21(1):12–26.

Drug Testing

- Drug testing during assessment and treatment should be conducted in alignment with the All Rise *Adult Treatment Court Best Practice Standards 2nd Ed.*, and national clinical standards, as found in *The ASAM National Practice Guideline for the Treatment of OUD, 2020 Focused Update*.
- Drug testing can be used in conjunction with participant self-report and should never be relied upon as the sole means for assessing substance use. Definitive testing should always be used when the results will help with clinical or treatment court decision-making.
- Positive testing alone should rarely result in detention or other stringent sanctions for participants with moderate to severe OUD who are otherwise substantially complying with court and treatment requirements (e.g., attending treatment sessions and court hearings and reporting for drug testing).
- Clinicians are perfectly positioned to advocate for participants who may have experienced a recurrence discovered by testing or self-report. This is an opportunity to openly communicate about engagement in treatment and triggers in the individual's life and environment. **An effective response to recurrence does not require punishment or reduction of privileges, but instead requires reassessment of the treatment plan.** This may include incorporation of motivation enhancement approaches, functional analysis of the recurrence, or other therapeutic adjustments, including changes to the dose or types of medications for OUD treatment.
- ASAM has published guidelines outlining best practices for drug testing in addiction settings entitled *The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine*.

Connecting Participants to an Appropriate Medication for OUD

- All persons in the court or other settings can assist the participant in gaining access to medications for OUD: judges, law enforcement officers, probation officers, counselors, etc.
- The courts should not determine which medications are available to a participant, nor should they attempt to help participants make decisions regarding medications for OUD. These are medical decisions.
- Counselors collaborate in shared decision making between the prescribing clinician and participant to choose from appropriate and available treatment options. Potential benefits and risks for each available option should be discussed.
- Prescribing clinicians consider the participant's current symptoms and co-occurring illnesses as well as their preferences, past treatment history, and setting when deciding between the use of methadone, buprenorphine, and extended-release naltrexone for OUD.
- Local and state agencies for addiction treatment usually maintain lists of credentialed providers, including those authorized to provide office-based treatment with buprenorphine.
- Contact state or county boards of health to identify medical practitioners offering addiction treatment in the local area.
- Linkage should include engaging the participant in understanding and consenting to medication and ensuring continuity of care through the use of coordinators, case and care managers, recovery coaches, peer mentors, etc.
- Peer support workers have been found to be helpful in the process to coordinate and bring criminal justice–involved persons to their appointments. Using such workers lowers the barrier to treatment.

Helping Participants Access Medication for OUD

- Many treatment courts rely on their treatment team members or local SUD treatment programs to determine whether medication is indicated and to identify qualified medical practitioners.
- Some treatment programs may have limited or no access to, or familiarity with, medications for OUD. In some cases, programs may be biased against medication. To effectively provide services to treatment court participants, treatment courts **must** use providers who are able to quickly connect participants with programs and professionals offering evidence-based treatments that include medication.

Medications for Initial and Continued Treatment of OUD

- All medications above have been shown to reduce cravings for opioids, recurrence, and opioid overdose in large clinical trials.
- These medications also help retain people in treatment and decrease illegal opioid use and property crime.
- The NIH HEAL Initiative has resources to help explain what the forms of medication for OUD are and how they help.
- Because opioid addiction is a chronic disease like heart disease or diabetes, it can require medication for many years or even for life.
- **Prematurely stopping medication for OUD can quickly lead to recurrence, overdose, and death.**

TABLE 3. THREE FORMS OF FDA-APPROVED MEDICATION FOR OUD

CHARACTERISTIC	METHADONE	BUPRENORPHINE	EXTENDED-RELEASE NALTREXONE
MECHANISM OF ACTION	Full opioid agonist	Partial opioid agonist	Opioid antagonist
DELIVERY	Oral	Sublingual film, injection	Injection
FREQUENCY	Daily	Daily oral Monthly injection	Monthly
SETTING	Licensed OTP that can provide services in a criminal justice system (CJS) setting	CJS, primary care, specialty care setting (X-waiver DEA: MD with 8 hours training; PA/NP with 24 hours training)	CJS, primary care, specialty care setting (no special licensing)

Agonist, Partial Agonist, and Antagonist Treatment

The different medications for OUD are based on their activity on the mu opioid receptor in the brain. Opioid agonists, such as methadone, bind to and fully activate the receptor; partial agonists, such as buprenorphine, bind to and partially activate the receptor; and antagonists, such as naltrexone, bind to the receptor but do not activate it, and they block other opioids from binding to and activating the receptor. All are effective treatments for OUD.

Agonists act on the opioid receptor to alleviate withdrawal and cravings, but when used properly, they do not provide the same euphoria, or "high," of a misused opioid. Methadone has the longest medical history of effectiveness in reducing opioid use and overdose and is dispensed only in federally licensed OTPs that typically dispense and administer the medication daily.

Methadone (Agonist)

- Methadone is a treatment option recommended for participants with OUD who may benefit from daily dosing and supervision to increase adherence and/or for those for whom buprenorphine or extended-release naltrexone has been unsuccessful.
- The administration of methadone is monitored until the participant's clinical response and behavior demonstrate that the prescribing of nonmonitored doses is appropriate.
- Abrupt discontinuation of methadone causes acute withdrawal. Participants should be warned about this and encouraged not to miss appointments or medication doses.
- Participants who discontinue treatment with methadone and then resume opioid use should be made aware of the risks associated with opioid overdose, especially increased risk of death.
- Participants and treating clinicians should be aware that acute pain requiring hospitalization, such as surgery or major trauma, often requires higher doses of opioids to overcome opioid tolerance. As many physicians are not comfortable treating addiction, participants should ask their prescribing clinician for a letter of support in these cases, stating that they take a medication for OUD, the dosage, and a suggested plan for pain control.
- **Low doses of methadone (less than 40 mg) are not shown to be effective in mitigating cravings.**
- The titration of methadone to an effective dose to reduce cravings is a slow process, and during this time, opioid use is not uncommon in patients. An effective dose is reached when opioid craving and use have diminished while observing for opioid side effects such as sedation.

Partial agonists, as the name implies, produce effects similar to full agonists but have fewer opioid-related side effects. Buprenorphine is the most effective partial agonist medication to reduce opioid craving and use and can be prescribed in any clinic where either a doctor (MD, DO) or advanced practice provider (physician assistant or nurse practitioner) has received extra training and an X-waiver on their Drug Enforcement Agency (DEA) license.

Buprenorphine (Partial Agonist)

- For participants actively using opioids, buprenorphine should not be started until they are experiencing mild to moderate opioid withdrawal to reduce the risk of precipitated withdrawal. Those who have a history of OUD but no active use and are at risk of opioid recurrence can start buprenorphine without evidence of withdrawal. A lower dose may be effective for these participants compared with actively using participants, and the length of the induction period may be longer.
- Unlike methadone, buprenorphine has a fixed maximum effect on the opioid receptor and can quickly (within 1 to 3 days) be titrated to the recommended 16 to 24 mg dose in persons with current OUD in opioid withdrawal.
- Buprenorphine may be started in a medical office, hospital, or jail/prison or at home.
- While all treatment court participants will participate in psychosocial treatment, such treatment is not necessary before beginning buprenorphine treatment, per the 2020 ASAM guideline for the treatment of OUD and SAMHSA TIP 63, *Medications for Opioid Use Disorder.*
- Some participants who are stable after long-term treatment may decide to try tapering off the medication. Buprenorphine taper and discontinuation is a slow process (over several months), and close monitoring by the prescribing clinician is recommended.
- Abrupt discontinuation of buprenorphine precipitates acute withdrawal and increases the risk of opioid overdose. Participants should be warned about this and encouraged not to miss appointments.
- Participants and treating clinicians should be aware that acute pain requiring hospitalization often requires higher doses of opioids, but use of buprenorphine can also help manage comorbid pain and OUD. As many physicians are not comfortable treating addiction, participants should ask their prescribing clinician for a letter of support in these cases, stating that they take a medication for OUD, what medication they take, the dose they take, and a suggested plan for pain control.

Antagonists work by blocking the action of opioid receptors. If a participant is treated with an antagonist medication and then starts to use opioids, the antagonist will block the opioid receptors, and the patient will not feel any effects from the opioid. Additionally, if an opioid antagonist is given to someone with active opioid use, precipitated withdrawal will occur.

Extended-Release Naltrexone (Antagonist)

- Naltrexone is a treatment option for preventing recurrence for those in remission from moderate to severe OUD, particularly among highly motivated participants likely to continue to adhere to treatment following the completion of criminal justice monitoring.
- To start naltrexone, a person must be abstinent from opioids for at least 7 to 10 days.
- Oral naltrexone (Revia) has not been found to be effective for treatment of OUD; however, the injectable monthly formulation, extended-release naltrexone, has been found to be effective for treatment of moderate to severe OUD.
- Extended-release injectable naltrexone is a monthly injection shown to be more effective than psychosocial treatment alone at reducing recurrence risk and equally effective as sublingual buprenorphine in large randomized controlled trials. **Naltrexone has no risk for diversion or overdose.** However, individuals who stop taking naltrexone and experience a recurrence are at increased risk for overdose.

  > *Patients maintained on naltrexone will have diminished tolerance to opioids and may be unaware of the consequent increased sensitivity to opioids if they stop taking naltrexone. Patients who discontinue antagonist therapy should be made aware of this phenomenon. If the patient stops naltrexone and resumes use of opioids in doses that do not reflect the degree to which they have lost tolerance, there is risk of an opioid overdose.* (*The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update*, page 45.)

- There is no recommended length of treatment with extended-release injectable naltrexone. Duration depends on clinical judgment and the participant's individual circumstances. Because there is no physical dependence associated with naltrexone, it can be stopped abruptly without withdrawal symptoms, although as discussed above, there is an increased risk of overdose with recurrence due to decreased tolerance to opioids during the period of abstinence.
- As with opioid agonists and partial agonists, participants who discontinue antagonist therapy and resume opioid use should be made aware of the increased risks associated with an opioid overdose, and especially the increased risk of death due to loss of opioid tolerance and hypersensitivity to opioids.
- Participants should be made aware that acute pain requiring hospitalization, such as surgery or major trauma, often requires nonopioid analgesia after starting extended-release naltrexone and is best managed in conjunction with an anesthesiologist or pain management expert. When feasible, injectable naltrexone should be discontinued at least 30 days prior to planned surgery.

Levels of Care for OUD Treatment and Treatment Courts

- When *The ASAM Criteria* are applied in treatment courts, the full continuum of levels of care should be available to participants.
- Clinicians should understand the levels (and sublevels) of care within *The ASAM Criteria*:
  - Level 0.5: Early Intervention, Level 1.0: Outpatient Services, Level 2.0: Intensive Outpatient/Partial Hospitalization Services, Level 3.0: Residential/Inpatient Services, and Level 4.0: Medically Monitored Intensive Inpatient Services.
- **Incarceration is not a level of care.** Participants are not incarcerated to obtain access to (or due to the absence of) detoxification services and sober living quarters, while awaiting a residential treatment bed, to prevent overdose, or to achieve other clinical or social service objectives. Using jail to prevent OUD-related self-harm should be used rarely if at all.[4] Decisions to use jail in this way must comport with legal standards and procedural requirements at least as stringent as those required to civilly commit an at-risk person living with mental illness to a locked inpatient psychiatric facility.
- **Even brief incarceration without medication for OUD increases the risk of overdose immediately after release.** The level of care a participant receives for treatment should match that person's severity of illness and functional level. A one-size-fits-all approach is not appropriate when determining the level of care for participants.
- The participant should not be placed in a residential setting if there is no clinical reason that requires a 24-hour setting (i.e., high potential for continuing use with imminent danger and toxic living environment).

[4] See the All Rise *Adult Treatment Court Best Practice Standards 2nd Ed.* for full details.

- Specific provision of services, including medication for OUD, should be available at every level of care, including residential.
- Participants should not terminate treatment with agonist or antagonist medications without careful consultation with the prescribing physician, as discontinuing treatment increases the risk for withdrawal, recurrence, overdose, and death.
- For all participants in treatment courts, medication for OUD should be provided in combination with psychosocial treatment, as it can prevent recurrence of use, overdose, and death at every level of care.
- Clinicians should be aware that not all treatment settings provide medication for OUD.
- All participants should have access to all three types of medication for OUD, with individualized treatment based on clinical assessment and participant preference.

Considerations for Psychosocial Treatment

- Treatment planning should anticipate circumstances in which participants do not adhere to recommended plans for, or referrals to, psychosocial treatment. This includes renegotiation of the treatment plan between the participant and the clinician, and involvement of other team members to achieve compliance and engagement.
- While essential for the typical treatment court participant to mitigate criminogenic risk and support recovery management, psychosocial treatment, including recurrence prevention, is not necessary to begin any form of medication for OUD, including extended-release naltrexone. Refer to the 2020 ASAM guideline for the treatment of OUD and SAMHSA TIP 63, *Medications for Opioid Use Disorder*.

Other Psychiatric, Medical, and Socioeconomic Needs

- Treatment court clinicians work to address barriers to treatment, including those posed by other members of the team. They should be aware of and prepared to proactively address stigma, discrimination, and other barriers that may impede a participant's access to evidence-based care.
- Persons in treatment court settings with OUD are at higher risk of other SUDs, chronic medical conditions, and psychiatric needs.
- They are also more likely to experience barriers accessing:
  - Housing
  - Healthcare
  - Transportation
  - Food
  - Childcare
  - Mental and psychiatric care
  - Employment
- These barriers impact a treatment court participant's engagement and retention in treatment for OUD and related services.

- The treatment court provides a reachable moment to not only address treatment for OUD but also to address the possible barriers to receiving medication for OUD.
- Other SUDs, as well as psychiatric needs, should be identified and addressed. This may include access to medication to treat mental health disorders.

Solutions

- Consider the option of telehealth, if available.
- Treatment court clinicians should have an up-to-date resource list available, including a list of OUD medication providers.
- Identified barriers should be routinely discussed with participants.
- Collaborate with divisions and grantees of the Department of Health and Human Services (DHHS).
- Collaborate with community resources for job searching and procurement.
- Collaborate with community resources for food services (food pantries, soup kitchens, etc.).
- Collaborate with housing areas and landlords accepting of this population.
- Maintain a list of childcare resources and support for applying for state-funded support of childcare.

Opioid Withdrawal and What To Do

TABLE 4. ACUTE OPIOID WITHDRAWAL SYMPTOMS		
SIGN OR SYMPTOM	**DESCRIPTION**	**NOTES**
Pulse rate	Elevated pulse rate (above 100 bpm) may indicate withdrawal	May also be elevated if participant has been moving about, is feeling anxious, or has consumed caffeine or other stimulants.
Runny nose or tearing	Nasal stuffiness, nose running	Check if symptoms could be attributed to a cold or allergies before administering opioid antagonist.
Lacrimation	Moist and tearing eyes	Check if symptoms could be attributed to a cold or allergies before administering opioid antagonist.
Mydriasis	Pupils appear larger than normal for room light	Observe pupils before administering antagonist to assess for change.
Piloerection	Piloerection of skin, or hair standing up on arms	Ensure that ambient temperature is not the cause.
Diaphoresis	Reports of chills and flushing, observable beads of moisture or sweat	Assess for participant activity, room temperature, and other external factors before attributing sweating to opioid withdrawal.
Chills	Reports of chills	Assess for participant activity, room temperature, and other external factors prior to attributing sweating to opioid withdrawal.
Anxiety or irritability	Irritability or anxiousness, observable or self-reported	Some participants may have anxiety at baseline, particularly in relation to administration of opioid antagonists. Assess at baseline and question about external cause of anxiety.
Yawning	Observed yawning during observation period	
Tremulousness	Tremors or muscle twitching	
GI symptoms	Stomach cramps, nausea, loose stools, vomiting, or diarrhea	If participant has recently been detoxed from opioids there may be some residual symptoms such as GI discomfort. It is important to assess these symptoms at baseline and monitor for a worsening of these symptoms.

Recognizing Opioid Withdrawal and Linking to Immediate Treatment

What is opioid withdrawal?

- Opioid withdrawal has a wide range of symptoms, as shown in Table 4, that occur after stopping or reducing the use of opioid drugs. With short-acting opioids, such as heroin or morphine, withdrawal can last up to 10 days, but it most often lasts between 3 and 5 days. With longer-acting opioids, such as methadone, symptoms peak between day 3 and day 8 and may persist for several weeks.
- Although opioid withdrawal can cause very troubling symptoms (such as vomiting, cramps, sweating, diarrhea, and dehydration), it is rarely life-threatening when treated appropriately. However, for the individual, these symptoms can be acutely distressing, potentially triggering suicidal thoughts and actions.

Opioid Withdrawal Management

- Using medications to control withdrawal is almost always recommended over managing withdrawal without medication.
- Specifically, buprenorphine and methadone can be started immediately to treat opioid withdrawal, following the ASAM or SAMHSA guidelines (see the Resources section).
- When participants try to quit "cold turkey," it can lead to risky complications, stronger cravings, and continued use, potentially leading to overdose and death.
- Withdrawal management on its own is not a treatment method. It may cause strong cravings, which can lead to continued use. In addition, the risk of death from fatal overdose is markedly increased after withdrawal management due to the loss of tolerance and high likelihood of return to use.
- Initiation of methadone or buprenorphine will quickly resolve withdrawal symptoms and can then be continued for maintenance treatment.
- Opioid withdrawal should be avoided during pregnancy due to fetal risk and potential for return to use. Buprenorphine and methadone can be safely administered during pregnancy. See the 2020 ASAM guideline for the treatment of OUD.
- If a participant takes buprenorphine or methadone for withdrawal management, the gold standard would be to continue this medication for the effective treatment of OUD. However, if a participant chooses not to continue medication for OUD, using medications for opioid withdrawal is recommended over abrupt cessation of opioids.

Recognizing Opioid Overdose

Signs and Symptoms of an Opioid Overdose

During an overdose, breathing can be dangerously slowed or stopped, causing brain damage or death. It is important to recognize the signs[5] and act fast. Signs include:

- Small, constricted "pinpoint" pupils
- Falling asleep or loss of consciousness
- Slow, shallow breathing
- Choking or gurgling sounds
- Limp body
- Pale, blue, or cold skin

[5] Source: CDC, *Preventing an Opioid Overdose* Tip Card.

What To Do If You Think Someone Is Overdosing

1. Call 911 immediately.
2. Administer naloxone, if available.
3. Try to keep the person awake and breathing.
4. Lay the person on their side to prevent choking.
5. Stay with them until emergency workers arrive.

- It may be hard to tell if a person is high or experiencing an overdose. If you are not sure, it is best to treat it like an overdose—you could save a life.
- Naloxone, available as an injection or intranasal spray, should be given in cases of known or suspected opioid overdose.
- Many times, more than one dose of naloxone is necessary.
- Naloxone can and should be administered to pregnant women in cases of overdose to save the mother's life.
- Participants being treated for OUD and their family or significant others should be given naloxone or prescriptions for naloxone (including at least two doses of medication).
- Treatment court staff, probation and parole officers, judges, prosecutors, and others with direct participant contact should be trained and authorized to administer naloxone if laws, court rules, regulations, and similar stipulations permit.
- Correctional health staff should be trained and authorized to administer naloxone as recommended in the 2020 ASAM guideline for the treatment of OUD.

Communication Within the Treatment Court Setting

- In addition to providing direct treatment services, clinicians should advocate on the team for the humane and effective treatment of addiction.
- Treatment providers share if and how the participant is responding to medication for OUD and other aspects of treatment.
- Treatment reports should include the quality of the participant's engagement and their recovery management progress, in addition to reporting on attendance and compliance.
- Treatment for OUD includes not just reduction in opioid use but engagement with family, employment, and education and avoiding criminal activity.
- Team members contribute relevant insights, observations, and recommendations based on their professional knowledge, training, and experience. The judge considers the perspectives of all team members before making decisions that affect participants' welfare or liberty and explains the rationale for such decisions to team members and participants.
- The judge's decisions and orders regarding treatment should be based solely on the assessment and recommendation of medical professionals and treatment professionals and the participant's preferences.[6]

[6] See the All Rise *Adult Treatment Court Best Practice Standards 2nd Ed.* for full details.

Resources

Resources for Finding Treatment Providers

The following websites provide directories of physicians, nurse practitioners, physician assistants, and treatment agencies specializing in addiction medicine and addiction psychiatry. Most of the websites can be queried by city, state, and zip code to identify medical practitioners located close to a treatment court.

- American Board of Addiction Medicine, Find a Physician: abam.net/find-a-physician
- American Board of Preventive Medicine, Physician Lookup: certificationmatters.org/find-my-doctor
- American Board of Psychiatry and Neurology, Search for an ABPN Board-Certified Physician: apps.abpn.org/verifycert
- American Academy of Addiction Psychiatry, Addiction Psychiatrists by State: aaap.org/education/resources/patients/find-a-specialist/
- SAMHSA, Find Treatment: findtreatment.gov
- SAMHSA, State Opioid Treatment Authorities: samhsa.gov/medication-assisted-treatment/sota
- SAMHSA, Behavioral Health Treatment Services Locator: findtreatment.gov
- Vivitrol, Find a Treatment Provider: vivitrol.com/find-a-treatment-provider

ASAM Resources

- American Society of Addiction Medicine Patient Resources: asam.org/publications-resources/patient-resources
- *The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine:* asam.org/quality-care/clinical-guidelines/drug-testing
- *The ASAM Criteria:* asam.org/asam-criteria
- *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update:* asam.org/quality-care/clinical-guidelines/national-practice-guideline
- *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use:* asam.org/quality-care/clinical-guidelines/national-practice-guideline
- ASAM best practices for drug testing in addiction settings:Jarvis, M., Williams, J., Hurford, M., Lindsay, D., Lincoln, P., Giles, L., Luongo, P., & Safarian, T.Appropriate use of drug testing in clinical addiction medicine, *Journal of Addiction Medicine* 11(3) 163–173. journals.lww.com/journaladdictionmedicine/Fulltext/2017/06000/Appropriate_Use_of_Drug_Testing_in_Clinical.1.aspx
- ASAM Definition of Addiction: asam.org/quality-care/definition-of-addiction
- Free webinars and additional material about treatment: asam.org/education

All Rise Resources

- To see all resources related to MAT, visit allrise.org/resources and filter by topic "Medication for Addiction Treatment"
- *Adult Treatment Court Best Practice Standards 2nd Ed.:* allrise.org/publications/standards

Other Clinical Resources

- Centers for Disease Control and Prevention (CDC), Preventing an Opioid Overdose Tip Card: cdc.gov/drugoverdose/pdf/patients/Preventing-an-Opioid-Overdose-Tip-Card-a.pdf
- American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5): psychiatry.org/psychiatrists/practice/dsm
- National Academies Press, Medications for Opioid Use Disorder Save Lives: nap.nationalacademies.org/catalog/25310/medications-for-opioid-use-disorder-save-lives
- Providers Clinical Support Services: pcssnow.org
- RODS screening tool: Wickersham, J. A., Azar, M. M., Cannon, C. M., Altice, F. L., & Springer, S. A. Validation of a brief measure of opioid dependence: The Rapid Opioid Dependence Screen (RODS). *Journal of Correctional Health Care,* 21(1):12–26.
- SAMHSA, TIP 63: *Medications for Opioid Use Disorder* (updated in 2021): store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006
- SAMHSA, State Targeted Response Technical Assistance (STR-TA): samhsa.gov/state-tribal-opioid-response-technical-assistance

This guide was created by addiction medicine specialists with criminal justice expertise from the American Society of Addiction Medicine (ASAM) and treatment court professionals with addiction treatment expertise from All Rise (formerly the National Association of Drug Court Professionals). It reflects up-to-date, evidence-based information to support good outcomes for individuals living with opioid use disorder.