



National Judicial Opioid Task Force

Treatment of Opioid Use Disorder

This document is designed to further educate justice system professionals about Opioid Use Disorder (OUD) and call attention to key issues surrounding medication assisted treatment (MAT), the evidence that underlies treatment types, best practices, and legal implications.

Medication Assisted Treatment: Evidence-Based and Best Practices

Drug or alcohol use disorders result in long-term physiological changes to regions of the brain that influence motivation, decision-making, and behavior, particularly around using or seeking drugs. Cessation of drug use alone does not return the brain to normal and relapses are to be expected.

Medication assisted treatment (MAT) combines the use of counseling and behavioral therapies with Food and Drug Administration (FDA)-approved medications to treat opioid use disorder (OUD). Under federal law, persons receiving medications for OUD must also be offered counseling (though they are not required to accept it).

Methadone, buprenorphine, and naltrexone have been associated with significantly reduced use of unauthorized opioids among probationers, parolees, and other persons with OUDs in the justice system. Unapproved or novel devices, herbal products, drugs, or drug combinations are not substitutes for FDA-approved medications.

A common myth is that MAT simply replaces one drug of abuse with another. When used as directed, methadone and buprenorphine reduce cravings and withdrawal. They prevent relapse without a “high.” Naltrexone is not opioid-based. These forms of medications are approved by the FDA, and many randomized clinical trials have demonstrated that they are effective and well tolerated.

No scientific basis exists for concluding that any one medication is superior to another in reducing unauthorized opioid use. One exception is that buprenorphine is superior to methadone for use by pregnant women, as fetal outcomes are better. Naltrexone has not been studied, and therefore is not recommended for use by pregnant women or women who are expecting to become pregnant.

Referrals for treatment services are routinely ordered by courts. Those who receive both medications and therapy are receiving MAT (MAT = Medication + Therapy). Medication use in conjunction with behavioral health therapy is optimal; however, research suggests that the medications are the more effective aspect of the treatment. Without medication, it is difficult to make good use of therapy and other recovery supports in persons with OUD.

There is no “one size fits all” MAT. Each option should be available to communities, and the selection is best decided between the individual and their healthcare practitioner. Treatment may be lengthy as an individual engages with aspects of recovering (i.e., housing, employment, parenting). Because the brain will generate cravings for years, MAT may be helpful over a long period of time.

FDA-Approved Medications Used in MAT

Methadone is a long-acting opioid which prevents cravings/withdrawal and is used to treat pain. It is available in pill, liquid, and wafer forms. Liquid methadone is the most common form used to treat OUD in the U.S., but the other forms are permitted. Methadone is ideal for people who need structure in their treatment but are stable enough for outpatient treatment. Users must initially attend the clinic daily to receive doses but may be provided “take home” doses as time passes and compliance with the treatment program is shown.

Methadone is only dispensed in specially regulated clinics called Opioid Treatment Programs (OTPs). It is illegal for physicians to prescribe methadone for OUD treatment outside of an OTP. (Non-OTP prescribing of methadone for treatment of pain is legal.)

Described as an opioid “agonist,” methadone acts on the opioid receptor like opium would and tricks the brain into thinking it is still getting the abused drug. In fact, the person is not getting high and feels normal, so withdrawal does not occur, if it is taken daily. Taking a higher dose than prescribed may result in intoxication.

Methadone is appropriate for women with OUD who are pregnant or breastfeeding. Strict compliance with the treatment standard of care minimizes concerns about methadone, such as interactions with other drugs and misuse.

Buprenorphine (also known as Suboxone or Zubsolv when combined with naloxone or Subutex when sold by itself) is an opioid partial “agonist.” Available as a daily dissolving tablet, cheek film, six-month implant under the skin (Probuphine), or monthly intramuscular injection (Sublocade), it is most often sold with naloxone, making efforts to get high through injection ineffective.

It is described as a “partial agonist” because it simultaneously activates and blocks the opioid receptors in the brain so that other opioids have no effect. This combined effect results in a “ceiling effect” that makes it safer than agonist medications, like methadone, when taken in high doses.

The Drug Addiction Treatment Act of 2000 waived the requirement of a separate Drug Enforcement Administration (DEA) registration for physicians to prescribe or administer buprenorphine, subject to application for a waiver and certain conditions. Physicians who prescribe buprenorphine products to treat OUDs must complete special training and then apply for a DEA license to prescribe buprenorphine in office-based settings (not in OTPs). The Comprehensive Addiction and Recovery Act of 2016 expanded the ability to get a waiver to nurse practitioners and physician assistants, again subject to specific conditions.

- Buprenorphine can be prescribed within OTPs without a waiver, or in hospital settings for up to 72 hours.
- Buprenorphine containing products can be filled at pharmacies in outpatient settings. There is no requirement that a patient receive any kind of behavioral intervention if they are prescribed buprenorphine. Prescribers must ensure that a comprehensive treatment plan is in place. Oral outpatient treatment may not be a good fit for a person needing a structured treatment program, while long-acting buprenorphine implants or injections may be preferable.
- Buprenorphine (Subutex) is safer than withdrawal in pregnant women, while methadone is acceptable, and naltrexone is not recommended.

Naltrexone is a non-addictive opioid “antagonist” that occupies the opioid receptor without activating it and therefore blocks the effects of other narcotics. It is available as a daily pill (which is less effective) or a monthly gluteal injection (i.e., Vivitrol). Naltrexone is also an FDA-approved and evidence-based treatment for alcohol use disorders.

A person must have stopped taking opioids for 7-10 days prior to receiving naltrexone to avoid a serious form of withdrawal called “precipitated withdrawal.” Difficulty abstaining for 7-10 days in the home environment often results in naltrexone treatment beginning in inpatient or residential settings. The person can then be released and receive their future doses in outpatient settings.

Overdose Reversal Medication

Naloxone is an opioid “antagonist” that binds to opioid receptors to reverse and block the effects of other opioids. It can quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with heroin or prescription opioid pain medications. It is available as a nasal spray, autoinjector, or injectable form (medical personnel only). Many states have issued standing prescriptions for naloxone to increase access to the medication. It is often used by first responders such as emergency medical services. It is recommended that individuals with OUDs have access to naloxone at all times.

Legal Implications

Prescription Drug Monitoring Programs

Every state has a Prescription Drug Monitoring Program (PDMP). It collects information on the prescribing and dispensing of controlled substances statewide. Access to information contained in this database varies by state based on provisions in statute or regulations.

While the primary utilizers of PDMPs are prescribers and pharmacists, states have granted access to justice system practitioners including: law enforcement, prosecutors, community supervision agencies and drug courts. Reports obtained from PDMPs are a tool to be utilized by the court primarily to assist in monitoring compliance of those under court order/supervision and to monitor compliance with medication regimens.

Americans with Disabilities Act

Title II of the Americans with Disabilities Act protects qualified individuals with disabilities from discrimination on the basis of disability from services, programs, or activities provided by state and local government entities.

A person with OUD may be a “qualified individual with a disability.” 28 CFR §35.130.

- Blanket refusal of MAT could be considered prohibited discrimination and problematic.

In most cases, a public entity may base a decision to withhold services if an individual is engaged in the current illegal use of drugs. 28 CFR §35.131.

- Prescribed MAT treatment is described as legal use.
- The prohibition on discrimination does not preclude reasonable policies or procedures requiring drug testing to ensure adherence.

Privacy and Confidentiality

The HIPAA Privacy Rule (45 CFR Part 164) and the Substance Abuse Confidentiality Regulations (42 CFR Part 2) may be implicated for the entities working with individuals who have been diagnosed with or are receiving substance abuse treatment services.

- A Part 2 program may disclose patient information to individuals within the criminal justice system. However, disclosure is limited to those who have made participation in the Part 2 program a condition of the disposition of criminal proceedings against the patient. Strict rules apply,

including patient consent revocation, and restrictions on re-disclosure. 42 CFR § 2.35.

Part 2, Subpart E (§§2.61-2.67) provides specific rules applying to court orders authorizing the disclosure and use of patient information protected by Part 2.

- Under Part 2, a treatment provider may disclose confidential information under a court order.
- However, if the context is a criminal matter, quite specific preconditions and assurances apply.

States often have statutes, rules and regulations related to privacy and confidentiality that are stricter than federal rules. Courts should be familiar with state statutes, rules and regulations should they exist.

Additional Information

Visit www.ncsc.org/opioidtaskforce for additional information regarding judicial initiatives, legislation, and solutions in response to this national epidemic.



Acknowledgments

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Sources

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SAMHSA, <https://www.samhsa.gov/medication-assisted-treatment>

SAMHSA Treatment Improvement Protocol (TIP) #63: Medications for Opioid Use Disorder (2018).
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SAMHSA Clinical Guidance for Treating Pregnant and Postpartum Women with Opioid Use Disorder and Their Infants (2018). <http://bit.ly/ppwnas>