THE NATIONAL JUDICIAL COLLEGE

BENCHCARD

Medication for Opioid Use Disorder

- Medication for Opioid Use Disorder (MOUD), formerly known as Medication Assisted Treatment (MAT), is an important tool in treating Opioid Use Disorder (OUD). The science demonstrating the effectiveness of MOUD is strong and people with OUD should have access to the medication most appropriate for them. Ideally, people should have access to all three FDA-approved medications.
- The three FDA-approved MOUDs are methadone, buprenorphine, intramuscular (IM) naltrexone.
- However, remission and recovery do not occur only through medication. Some people achieve remission without MOUD, just as some people can manage type 2 diabetes with exercise and diet alone. It is inadvisable to deny people with diabetes the medication they need to help manage their illness. It is also not sound medical practice to deny people with OUD access to FDA-approved medications for their illness.
- Discontinuing medication increases risk of return to drug use and overdose death. Expert opinion supports maintaining patients on MOUD for years, decades, and even a lifetime if patients are benefitting.
- Patients may benefit from different levels of care at different points in their lives, including outpatient counseling, intensive outpatient treatment, inpatient treatment, or long-term therapeutic communities. Programs should offer a full range of services accepted as effective in treatment and recovery, which should be matched to a person's needs. See the list of 5 signs of quality treatment programs (https://store.samhsa.gov/sites/default/files/d7/priv/pep18-treatment-loc.pdf) created by the Substance Abuse & Mental Health Services Administration (SAMHSA)
- Currently, no empirical data indicate which patients will respond better to which MOUD and the choice of medication should be matched to the person following a full medical assessment and patient-centered discussion.

1. Methadone

- Most studied & used MOUD to treat people throughout the world with the longest track record (nearly 50 years). Research shows it's associated with significantly higher rates of treatment retention & lower rates of illicit opioid use compared with placebo and with no treatment; as well as reduction in mortality, criminal behavior, and HIV seroconversion.
- Only dispensed at federally-certified opioid treatment programs (OTPs); patients must present 6 days/week for treatment for the first 90 days & receive only one "take-home dose" a week. As treatment progresses, OTPs can provide gradually increasing numbers of take-home doses to patients, which is a powerful incentive for patients to achieve treatment goals.

POTENTIAL ADVANTAGES OF METHADONE:

1. Strongest evidence for treatment retention and remission of OUD symptoms
2. Lowest cost
3. High-intensity monitoring and treatment, especially early in treatment

POTENTIAL DISADVANTAGES OF METHADONE:

1. Not uniformly accessible; most OTPs are located in urban areas and not accessible to rural communities
2. Limited maximum supply of medication dispensed at a time, no refills
3. DEA Schedule II medication with potential for diversion/misuse

[1] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020, p. 3-11.

PCSS Providers Clinical Support System

2. Buprenorphine

- Approved by FDA in 2002; a safer MOUD than methadone as it's less likely to cause respiratory depression.
- Can be prescribed in an outpatient office, unlike methadone which requires a specifically authorized clinic. Still, a shortage of providers who prescribe buprenorphine exists and underrepresented minorities have less access to this effective medication.[2]

POTENTIAL ADVANTAGES OF BUPRENORPHINE:

1. Available in outpatient settings
2. DEA Schedule III medication with lower potential for diversion/misuse
3. Significantly lower risk of overdose; lesser opioid effects
4. More flexible dosing; may receive up to 30-day supply or 4-week injectable; available for refills.

POTENTIAL DISADVANTAGES OF BUPRENORPHINE:

1. Not uniformly accessible
2. Higher cost
3. Though generally less than methadone, still has opioid effects (constipation, nausea, headache)

3. IM Naltrexone

- Most recent FDA-approved MOUD. In 2010, naltrexone, which was previously given orally, was approved to be given intramuscularly (IM) as a monthly injection; it blocks the effects of opioids.
- Before using this MOUD, patients must undergo, or have undergone, opioid withdrawal. In patients who are no longer opioid dependent (e.g., individuals with a history of OUD who are returning from controlled environments including incarceration), IM Naltrexone may be considered.
- Pregnant women are not appropriate candidates for IM naltrexone treatment.

POTENTIAL ADVANTAGES OF IM NALTREXONE:

1. Not DEA Scheduled (i.e. not controlled); no abuse potential
2. Eliminates physical dependence (tolerance)
3. Monthly injectable, no need for daily medications.

POTENTIAL DISADVANTAGES OF NALTREXONE:

1. Must go through withdrawal before starting
2. High cost
3. High risk of overdose if medication discontinued and person restarts opioids

Judicial Role and Responsibilities to Clients with OUD

- Judges are not doctors and have no more authority, training or expertise to decide whether someone should be prescribed a MOUD or which type of MOUD is right for than to determine which antipsychotic medication is right to prescribe to a patient.
- Judges must honor the physician-client relationship and course of treatment; only making decisions within our scope based on evidence presented and evaluation of expert testimony within a full due process hearing. See NADCP's Resolution regarding MOUD (MAT) for Addiction in Drug Courts. (https://www.ndci.org/wp-content/uploads/2016/07/NADCP-Board-Statement-on-MAT.pdf)
- Judges must do better communicating between courts and medical professionals because MOUD is essential treatment for clients and a significant portion of people seeking MOUD are justice involved.
- Judges must create venues (including contested hearings) to communicate and learn from the other disciplines involved in treatment in order to improve outcomes and save lives.

TIPS FOR COMMUNICATING WITH CLIENTS WITH OUD

DO:

- Use open-ended questions
- Engage in active listening, summarize, ensure understanding
- Affirm
- Align with client motivation and goals
- Roll with resistance
- Be trauma informed

DON'T:

- Expect perfection
- Let client ambivalence throw you. Ambivalence is expected and normal.
- See relapse as failure, character flaw or the end of the line. Relapse is expected and the norm. It's getting back in the fight that counts

[2] Lagisetty PA, Ross R, Bohnert A, Clay M, Maust DT. Buprenorphine Treatment Divide by Race/Ethnicity and Payment. *JAMA Psychiatry*. 2019;76(9):979–981. doi:10.1001/jamapsychiatry.2019.0876

Trauma Informed Practice/Motivational Engagement

- SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." Judges must:
    1. **Acknowledge** the prevalence and impact of trauma in our population.
    2. **Understand** that many behaviors that seem wrong to us are adaptations to cope with the impacts of past and ongoing trauma and not character or motivational flaws.
    3. **Seek** to create safety for healing and growth.
- Assumption should be that every individual encountered in the courtroom has experienced trauma. Reality is that justice-involved individuals struggling with substance abuse and/or mental health issues have generally experienced trauma.
- Engaging in trauma-informed practice is good practice and provides true access to justice. Trauma-informed judicial interaction starts with you: treating everyone who comes before you with dignity and respect and practicing active listening and connected communication directed toward engagement, motivation and success. SAMHSA's six key principals of a trauma-informed approaches are:
    1. **Safety:** Must create and hold spaces and interactions with clients that are fundamentally safe from their perspective, not just ours.
    2. **Trustworthiness and Transparency:** We are trauma-informed when our interactions are thoughtful, transparent and consistent. We need to show ourselves trustworthy before we can expect clients to be vulnerable and open.
    3. **Peer Support:** Access to independent peer support is essential to client success.
    4. **Collaboration and Mutuality:** Our people and systems must be building connection, support and alliance with clients.
    5. **Empowerment, Voice and Choice:** We must listen to our clients and their concerns, plans and choices. Dictating our preference or using one-size-fits-all will not succeed; they will not trust us until we prove ourselves trustworthy. Keep listening.
    6. **Cultural, Historical and Gender Issues:** We must be engaged in actively understanding and unearthing our biases, privilege and power. We must confront cultural, historical and gender issue impacts in our communities, systems and our client's experiences. We must identify and remove barriers.

Words Matter

- Carefully examine your word choices. Stigma, shame and demeaning language can activate and harm a person with a traumatic history.
    - ✓ Instead of "addict," a person has a substance use disorder.
    - ✓ Instead of being "clean," a person is abstinent or testing negative
    - ✓ Instead of being "dirty," a person is actively using or testing positive.
- Clients have generally been hearing and telling themselves negative messages for a very long time. We can help change the messaging and undo the stigma in our word choice and thoughtful reframes. See Words Matter – Judicial Language and Substance Use Disorders, National Judicial Opioid Task Force: https://www.opioidlibrary.org/wp-content/uploads/2019/06/NCSC_Words-Matter-Judicial-Language-and-SUD-final.pdf

Resources

- SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf
- The National Drug Court Institute's MOUD page: https://www.ndci.org/resource/training/medication-assisted-treatment/
- The National Judicial Opioid Task Force has a great collection of solid resources: https://www.ncsc.org/information-and-resources/resource-centers/resource-centers-items/opioids-and-the-courts/resource-center
- Essential Components of Trauma-Informed Judicial Practice: https://www.nasmhpd.org/sites/default/files/DRAFT_Essential_Components_of_Trauma_Informed_Judicial_Practice.pdf
- For training on Trauma-Informed Criminal Justice Practice please contact: https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals
- The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma, Bessel van der Kolk M.D.
- For additional information and trainings on MOUD: www.judges.org
- American Academy of Addiction Psychiatry Law and Medicine Guide: https://www.aaap.org/education/law-and-medicine-guide/

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