



**A Drug Court Clinician's
Guide for Linking People to
Opioid Treatment Services**
in Outpatient Offices, Clinics,
and Opioid Treatment Programs
(OTPs)

Introduction

This pocket guide is designed to help counselors and therapists working with drug court participants refer and link participants to opioid treatment services in outpatient offices, clinics, and Opioid Treatment Programs (OTPs).

This pocket guide was produced by the American Society of Addiction Medicine (ASAM) and the National Association of Drug Court Professionals (NADCP). It reflects up-to-date, evidence-based information and has been created by addiction medicine specialists and criminal justice experts to help support optimal outcomes for justice-involved individuals.

Readers will:

- Understand the effectiveness of medication-assisted treatment (MAT) for opioid use disorder (OUD) and reasons to include MAT in services offered to drug court participants.
- Review characteristics of state of the art addiction treatment and evidence-based practices related to MAT to effectively refer to MAT providers.
- Discuss assessment, diagnosis, and treatment setting decisions for participants with OUD.
- Review specific treatment issues, including opioid overdose and withdrawal, the use of MAT, and psychosocial treatments.
- Apply knowledge and skills about evidence-based practices to discuss MAT options and link drug court participants to MAT providers.



Understanding Addiction and Medication in Addiction Treatment

Addiction is “a primary, chronic disease of brain reward, motivation, memory, and related circuitry,” with a “dysfunction in these circuits” leading to “characteristic biological, psychological, social, and spiritual manifestations.” Brain changes result in the pathologic behavior of pursuing reward and/or relief by substance use and other maladaptive behaviors.¹

Addiction is about a physiologic change in the brain – not just about behaviors. While it is crucial to consider psychosocial and behavioral interventions in addiction treatment due to their efficacy, it also is crucial to consider the use of medications necessary to address the pathologic changes in brain circuitry and improve outcomes in conjunction with comprehensive psychosocial treatment.

“National Institute on Drug Abuse (NIDA) Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide” identifies 13 principles, including:

Principle #2 states that recovery from drug addiction requires effective treatment, followed by management of the problem over time.

Principle # 5 indicates the need to tailor services to fit the needs of the individual as an important part of effective addiction treatment for criminal justice populations.

Principle # 12 identifies that medications are an important part of treatment for many people in the criminal justice system suffering from addiction.²

Opioid Overdose Risk and Medication Treatment

The rapid rise in opioid overdoses and deaths increases the need to urgently utilize all forms of treatment, including medications for OUD.

Medication-assisted Treatment:

- Represents scientifically supported treatment shown to reduce drug use and foster meaningful recovery. When appropriately dosed, medication should result in neither euphoria (“high”) nor sedation.
- Can help participants feel normal and prepare them for working on their recovery.
- Helps participants focus on their ongoing recovery by reducing cravings. Thus, participants should be supported in understanding and taking medication.
- Is **not** substituting one addictive drug for another. Medication has specific actions on neurotransmitter receptor sites to decrease cravings to use, shorten the length of any relapses, and improve overall addiction and recovery outcomes. Medication saves lives.
- Significantly increases treatment entry and retention among individuals on probation and parole.
- Combined with addiction counseling, is essential for the typical drug court participant with OUD and provides the best hope for recovery.
- Does not preclude drug court program progression or completion when used by a participant in ongoing addiction treatment.

Medication for Initial and Continued Treatment of OUD

Medication has been shown to be effective and is recommended for most people with moderate to severe OUD who are on parole or who are incarcerated, detained in jail, or on probation (regardless of the length of their sentence term). “Decisions about the appropriate type, modality and duration of treatment should remain the purview of the treatment provider and the patient, working in collaboration to achieve shared treatment goals.”³

- Individuals with OUD within the criminal justice system should have integrated care, and most should be treated with some type of medication in addition to psychosocial treatment.
- Opioid agonists (methadone), partial agonists (buprenorphine), and antagonists (naltrexone) may be considered for treatment.

Agonists	Act on the opioid receptor but have effects which are less intense, slower, and longer-lasting than opioids like heroin. This means that agonists alleviate withdrawal and craving but don't provide the same euphoria, or “high,” of the misused opioid.
Partial agonists	Produce effects that are similar to but weaker than those of full agonists
Antagonists	Work by blocking the action of receptors. Should a participant undergoing treatment with an antagonist-type medication relapse and use the formerly misused opioid, that drug's power to trigger the receptors is often blocked or greatly diminished. All participants should have access to all three types of medication with treatment based on participant preference and clinical assessment.

- Buprenorphine and naltrexone can be prescribed in an office-based setting and can also be dispensed in an OTP setting.
- Methadone can only be dispensed in regulated settings such as OTPs. OTPs provide medication treatment, including methadone, and counseling to participants with OUD. They are approved by the Substance Abuse and Mental Health Administration (SAMHSA), accredited by a licensing body, licensed by the state, and registered with the Drug Enforcement Agency (DEA).
- As with medication for other illnesses that need ongoing treatment, there is no recommended length of time for medication in addiction treatment. Treatment continues depending on severity of illness and outcomes and response to treatment. The continued use of medication should not preclude drug court program progress or completion.
- When medication is indicated, it should be initiated a minimum of 30 days prior to release from prison and be accompanied by assertive efforts of reentry or other drug court case managers to find providers to continue such treatment post-release.

Assessment, Diagnosis, and Treatment Setting Decisions for OUD

Assessment

- Assess and address any immediate, urgent, or emergent medical or psychiatric problem(s), including drug-related impairment or overdose.
- Use motivational enhancement and interviewing techniques and strategies that convey empathy while affirming steps toward recovery.
- Use multidimensional assessment for holistic care guided by The ASAM Criteria six assessment dimensions. (See <https://www.asam.org/resources/the-asam-criteria/about>)
- **Note:** This assessment ***must*** be conducted by a skilled clinician using a valid assessment tool that facilitates the

following of an ASAM Criteria multidimensional assessment, which includes the six dimensions listed below:

1. **Acute Intoxication and/or Withdrawal Potential** – Assess need for intoxication or withdrawal management services by taking a complete substance use history, e.g., alcohol, benzodiazepines and other sedative hypnotics, cannabis, stimulants, tobacco, or other addictive drugs.
2. **Biomedical Conditions and Complications** – Assess need for physical health services by completing medical history and screening for concomitant medical conditions, including infectious diseases (e.g., HIV, Hepatitis C), acute physical trauma, pregnancy, chronic pain, and reproductive health. This typically involves a physical examination and initial blood and urine testing.
3. **Emotional/Behavioral/Cognitive Conditions and Complications** – Assess need for mental health services by assessing mental health status, psychiatric disorders or addiction-related mental health signs and symptoms, e.g., mood swings from using stimulants (cocaine, methamphetamine) and depressants (alcohol, opioids) is not necessarily Bipolar Disorder. Untreated mental health disorders, including those related to emotional trauma, often contribute to addiction. Certain mental health disorders also might contribute to criminal behavior.
4. **Readiness to Change** – Assess need for motivational enhancement services by assessing participants’ interest and capacity for changing their substance use, mental illness, lifestyle, supports, etc.
5. **Relapse/Continued Use/Continued Problem Potential** – Assess need for relapse prevention services by assessing participants’ history of periods of abstinence, sobriety, and recovery, or reduced use and how they achieved that. For those currently using substances, including those with no previous periods of recovery or even those with periods of recovery, assess their ability to stop immediate continued use and/or continued mental health problems.

6. **Recovery and Living Environment** – Assess need for recovery support services by assessing social and environmental factors that are barriers to addiction treatment. Assess any addiction-driven criminal activity (whether the participant was arrested or not), such as selling drugs or committing crimes to obtain money to buy drugs; and identify strengths, skills, and resources that support treatment, including medications and involvement in a drug court. This often means changing “people, places, and things” that trigger alcohol or other drug use or addictive behaviors, such as gambling. Recovery also involves creating stability in housing, food, health care, and preparing for the future, such as education, job training, and employment as appropriate.

Diagnosis

- Prior to initiating pharmacotherapy for OUD, a diagnosis of OUD must be verified.
- Participants in active withdrawal should first have their withdrawal symptoms evaluated and treated by a provider using validated clinical scales for withdrawal symptoms.
- Diagnose and/or refer for evaluation of suspected mental health disorders.

Drug Testing

- Drug testing in assessment and during treatment should be conducted in alignment with national standards, such as the NADCP Adult Drug Court Best Practice Standards and the ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine. Drug testing should be used in conjunction with participant self-report and should never be used as the sole means for assessing substance use. It is crucial to tailor the choice of test and frequency to the clinical needs of the participant and avoid unnecessarily frequent or expansive testing, which is wasteful. The clinician ordering and interpreting the toxicology testing must understand the characteristics of the test. Definitive testing should always be used when the results will influence clinical or drug court decision-making. Positive testing alone should almost never

result in punitive sanctions or detention for participants with moderate to severe substance use disorder (SUD). The focus of any sanctions must be related to treatment adherence and candor, not solely ongoing substance use.

- ASAM has guidelines outlining best practices for drug testing in addiction settings: “ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine.”⁴
- NADCP has developed a set of standards outlining how drug testing is applied in drug court settings.⁵

Referring to an Appropriate Treatment Setting

- Counselors collaborate in shared decision-making between the prescribing clinician and participant to choose from available treatment options after discussing potential benefits and risks for different options available to the drug court participant.
- Counselors should understand the benefits of medication in addiction treatment to be able to discuss medication treatment options with participants and link the individual to a prescribing provider.
- Prescribing clinicians must consider participant preferences, past treatment history, and setting when deciding between use of methadone, buprenorphine, or naltrexone for OUD.

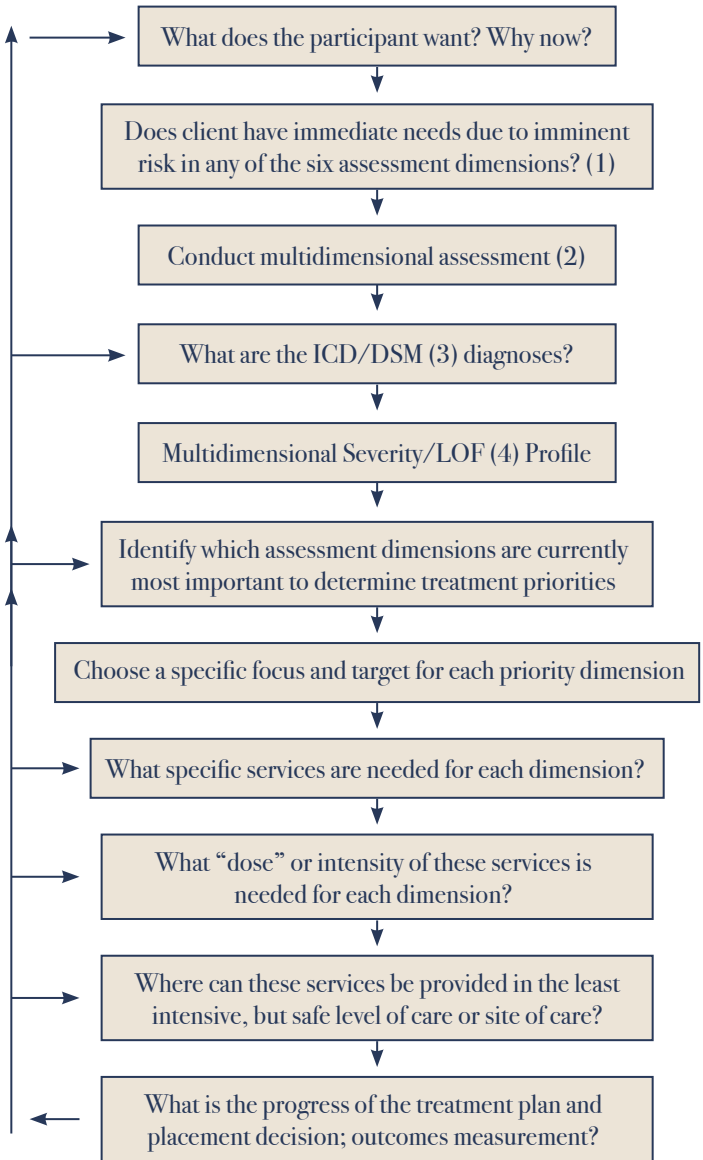


- The venue in which treatment is provided is as important as the specific medication selected.
- Prescribing clinicians will consider contraindications for office-based treatment such as active, severe alcohol or benzodiazepine use disorder.
- Link to an OTP with methadone for participants who may benefit from daily dosing, structure of the OTP model, and supervision, or for those for whom other medications have been unsuccessful in an office-based setting, or for whom other medications are not available (e.g., no prescribing physician in the community).
- To guide evaluation and ongoing assessment of needs, services, and level of care, the following decisional flow matches assessment, treatment, and placement assignment.

Key for chart on pg. 11

1. Imminent Danger/Risk (*The ASAM Criteria* 2013, pp. 65-58) - Three components:
 - A strong probability that certain behaviors (such as continued alcohol or other drug use or addictive behavior relapse) will occur.
 - The likelihood that such behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in reckless driving while intoxicated or neglect of a child).
 - The likelihood that such adverse events will occur in the very near future, within hours and days, rather than weeks or months.
2. Multidimensional assessment must be completed using a tool that allows for a comprehensive six-dimension assessment, such as ASAM's CONTINUUM.
3. International Classification of Diseases/Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association
4. Level of Function

Decision Flow to Match Assessment and Treatment/Placement Assignment



Specific Issues in Caring for Participants with OUD

These include opioid overdose and withdrawal; use of methadone, buprenorphine or naltrexone; psychosocial treatments; and special populations.

Responding to an Opioid Overdose

- Naloxone, available as an injection or an intranasal spray, should be given in known or suspected opioid overdose.
- Naloxone can and should be administered to pregnant women in overdose to save the mother's life.
- Participants being treated for OUD and their family and significant others should be given prescriptions for naloxone.
- First responders, such as emergency medical services personnel, police officers, and firefighters, should be trained and authorized to administer naloxone.

Steps in Addressing Overdose⁶

1 Call for Help (Dial 911)

2 Recognize the Signs of Overdose

- Inability to awaken verbally or upon sternal rub (the application of painful stimuli with the knuckles of closed fist to the center chest of a person who is not alert and does not respond to verbal stimuli).
- Slow or shallow breathing
- Fingernails or lips turning blue/purple
- Extremely small pupils – “pinpoint pupils”
- Slow heartbeat and/or low blood pressure

3***Administer Naloxone***

- Naloxone is available as an intranasal spray or an injection that can be given intravenously or intramuscularly.
- More than one dose of naloxone may be required to revive the person.

4***Support Respiration***

- Verify that the airway is clear.
- With one hand on the person's chin, tilt the head back and pinch the nose closed.
- Place your mouth over the person's mouth to make a seal and give two slow breaths (the person's chest should rise, but not the stomach).
- Follow up with one breath every five seconds.

5***Monitor the Person's Response***

- Most people respond to naloxone by returning to spontaneous breathing, with mild withdrawal symptoms within 3-5 minutes. (Rescue breathing should continue while waiting for the naloxone to take effect.)
- The duration of effect of naloxone is 30-90 minutes. People should be observed after that time for reemergence of overdose symptoms.

Stay with the person until emergency medical services arrive.

- **The goal of naloxone therapy should be restoration of adequate spontaneous breathing, but not necessarily complete arousal.**

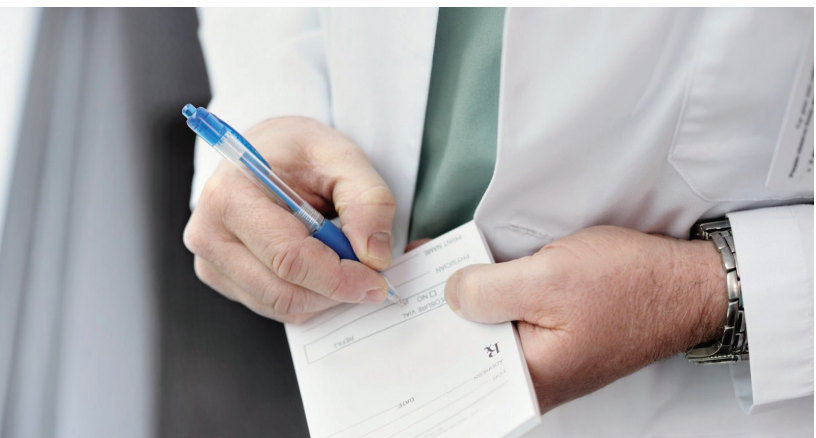
Managing Opioid Withdrawal

Opioid Withdrawal

- Opioid withdrawal refers to the wide range of symptoms that occur after stopping the use of opioid drugs. Withdrawal can last up to 10 days, but most often lasts between 3-5 days.
- Although withdrawal can cause very troubling symptoms (such as vomiting, cramps, and sweating), it is rarely life-threatening when treated appropriately.

Opioid Withdrawal Management (WM)

- Using medications to control withdrawal, such as methadone or buprenorphine (also called withdrawal management), is almost always recommended over trying to quit “cold turkey.” When participants try to quit “cold turkey,” it can lead to risky complications, stronger cravings, and continued use.
- Opioid WM on its own is not a treatment method. Abrupt cessation of opioids often leads to strong cravings, which can lead to continued use. In addition, the risk of death from fatal overdose is markedly increased after WM due to the loss of tolerance and high likelihood of relapse.



- Initiation of methadone or buprenorphine does not require completion of WM. These medications will resolve withdrawal symptoms when initiated and can then be continued for maintenance treatment.
- In the event that a participant is not initiating maintenance treatment, using medications for opioid WM is recommended over abrupt cessation of opioids. However, WM should always be followed by the initiation of long-term treatment.
- Opioid withdrawal should be avoided during pregnancy due to fetal risk and potential for relapse.
- Multidimensional assessment (ASAM Criteria six dimensions) is necessary for participants in opioid WM.

How to Introduce Medication to a Participant

Benefits

Medication treatment should be offered to every drug court participant assessed to benefit from it. The likelihood of sustained recovery is greatest for individuals on medication, which is important for counselors to understand and communicate to the participant. The risk of relapse and of overdose is also lowest for people on medication compared to other forms of treatment.

Barriers

Many participants may have been influenced by societal stigma about medication treatment and are confused by common misperceptions about the role of medication. For example, some people may have been told that they are “not sober” if they take a medication, or that they will become “addicted” to medication. Participants also may have had prior experiences of being forcibly withdrawn from medication treatment when incarcerated.

Barriers may be summarized as problems of the 3 A's:

1. Access to arrange for and receive medication.
2. Awareness of the science, importance, and procedures of medication.
3. Attitudes about medication that lead to discrimination against this clinical tool that can save lives and improve recovery outcomes.

Overcoming Barriers

Because medication is important to save lives and aid recovery, it is important to break down barriers and understand a participant's past experiences with medication and their perceptions of medication. For example, a counselor could start a conversation by saying, "We now know from research that people treated with medication are more likely to enter and stay in recovery. Have you ever tried a medication like methadone, buprenorphine, or naltrexone?"

For individuals who may have been affected by stigmatizing notions about medication, it is crucial to address and dispel myths and be clear that people taking medication are still sober and in recovery. In addition, taking a daily medication to manage a chronic illness is not the same as addiction. If it were, then any patient with diabetes taking insulin would be "addicted."

For individuals who have previously been forcibly withdrawn from medication while incarcerated, giving a painful experience of withdrawal to the participant, it is important to discuss and understand their fears to help guide treatment decision-making. In addition, wherever practically feasible, advocating for continuation of treatment even during incarceration is crucial. Please note that NADCP recommends against requiring participants to agree to medications as a prerequisite for drug court program participation or advancement.

Types of Medication-assisted Treatment

Methadone (Agonist)

- Methadone is a treatment option recommended for participants with OUD that includes withdrawal or increasing tolerance symptoms and who may benefit from daily dosing and supervision to increase adherence, and/or for those for whom buprenorphine has been unsuccessful.
- The usual daily dosage of methadone ranges from 60-120 mg, although some participants respond to lower doses, and some need higher doses.
- The administration of methadone is monitored until the participant's clinical response and behavior demonstrate that the prescribing of nonmonitored doses is appropriate. These nonmonitored doses are called "take homes" and allow a participant to manage a certain number of days of medication at home.
- Methadone should be reinstated immediately if relapse occurs, or when an assessment determines that the risk of relapse is high for participants who previously received methadone in OUD treatment, but who are no longer prescribed such treatment.
- Participants switching from methadone to buprenorphine should be on low doses of methadone, e.g., 40 mg or less, prior to switching medications in order to avoid precipitated withdrawal symptoms.

- Participants switching from methadone to naltrexone must be completely withdrawn from methadone and other opioids for 7-10 days before they can receive naltrexone.
- Abrupt discontinuation of methadone precipitates acute withdrawal. Participants should be warned about this and encouraged not to miss appointments.
- Participants who discontinue agonist therapy with methadone or buprenorphine and then resume opioid use should be made aware of the risks associated with opioid overdose, especially the 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 in order to overcome opioid tolerance.



Buprenorphine (Partial Agonist)

- Participants should wait until they are experiencing mild to moderate opioid withdrawal before taking the first dose of buprenorphine to reduce the risk of precipitated withdrawal.
- The usual daily dose of buprenorphine ranges from 8-24 mg daily.
- Buprenorphine may be started in a medical office or at home.
- Psychosocial treatment should be provided in conjunction with the use of buprenorphine in the treatment of OUD. Because most physicians who prescribe buprenorphine do not provide psychosocial treatment, the drug court will likely need to assist the participant to secure that treatment elsewhere in the community.
- Clinicians should take steps to reduce the chance of buprenorphine diversion.

Recommended strategies include frequent office visits (weekly in early treatment), toxicology testing, including testing for buprenorphine and metabolites, recall visits for pill counts, and formulations of buprenorphine that reduce diversion risk.

- Participants should be tested frequently for buprenorphine, as well as for illicit use of other substances, including prescription medications. Such testing is common in drug court programs, and treatment providers will likely be able to access these test results from the court.
- Accessing Prescription Drug Monitoring Program (PDMP) data may be useful for monitoring.
- Participants should be seen frequently at the beginning of their treatment. Weekly visits (at least) are recommended until participants are determined to be stable.

There is no recommended time limit for treatment.

- Some participants who are stable after long-term treatment may decide to try tapering off of the medication. Buprenorphine taper and discontinuation is a slow process, and close monitoring is recommended.

Buprenorphine tapering is generally accomplished over several months. Participants should be encouraged to remain in treatment for ongoing monitoring past the point of discontinuation.

- When considering a switch from buprenorphine to methadone, there is no required time delay.
- Abrupt discontinuation of buprenorphine precipitates acute withdrawal. Participants should be warned about this and encouraged not to miss appointments.
- Participants who discontinue partial agonist therapy and resume opioid use should be made aware of the risks associated with an opioid overdose, especially the increased risk of death. Overdose education and naloxone distribution should be made available.
- Participants and treating clinicians should be aware that acute pain requiring hospitalization, such as surgery or major trauma, often requires higher doses of opioids and/or stopping buprenorphine in order to overcome opioid tolerance.



Extended-release Naltrexone (Antagonist)

- Naltrexone is an antagonist medication. It is a treatment option for preventing relapse in OUD, particularly among participants who become highly motivated during the treatment process and are therefore 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 7-10 days.

Extended-release injectable naltrexone is a monthly injection, which has been shown to be more effective than no medication at reducing relapse risk over the short term (e.g., six months).

Naltrexone has no risk for diversion or overdose. However, individuals who stop taking naltrexone and experience a relapse are at increased risk for overdose.

Use of naltrexone results in the loss of opioid tolerance, potentially exposing participants who relapse to a fatal overdose similar to that observed following completion of withdrawal (“detox”) or following release from prison. This risk for relapse and overdose must be carefully considered, particularly following the end of court monitoring, when there may be less incentive for the individual to continue with naltrexone. Participants should be warned about this loss of tolerance.

- Psychosocial treatment, including relapse prevention, is recommended in conjunction with treatment with naltrexone.
- The efficacy of extended-release injectable naltrexone to treat OUD has not been confirmed when it has been used as pharmacotherapy without accompanying psychosocial treatment.
- 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 there is an increased risk of overdose with relapse due to decreased tolerance to opioids during the period of abstinence.

- Switching from naltrexone to methadone or buprenorphine is feasible, however lower initial doses of methadone or buprenorphine will be required initially.
- Participants who discontinue antagonist therapy and resume opioid use should be made aware of the increased risks associated with an opioid overdose, especially the increased risk of death from loss of opioid tolerance and hypersensitivity to opioids.

- When participants have been maintained on naltrexone, they will be more sensitive to opioids if they stop taking naltrexone. This means that they won't need as large of a dose of opioids to get the same effect as before. The danger in this is that if they relapse and take an amount of opioids that once gave them a high, that dose may be too large of a dose now, and they can overdose and even die. As a result, the drug court must work with them to ensure they have the support they need once the court is no longer supervising participants.
- Participants should be made aware that acute pain requiring hospitalization, such as surgery or major trauma, needs specialized management since naltrexone will block the effects of any opioid pain medication. Depending on the severity of injury/surgery, anesthesiologists can use non-opioid agents for sedation and pain relief during surgery, such as propofol or ketamine. When feasible, injectable naltrexone should be discontinued at least 30 days prior to planned surgery.

Special Populations: Pregnant Women

- For pregnant women with OUD, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, which lead to worse outcomes.
- Naltrexone is not recommended during pregnancy.
- More research is needed to assess the safety (particularly regarding maternal relapse), efficacy, and long-term outcomes of medically supervised withdrawal.⁷



Medications to Treat Opioid Addiction

Medication	Brand names
Buprenorphine	Probuphine [®] (implant) *, generics, Sublocade [™] (extended-release injection)
Buprenorphine and naloxone	Suboxone [®] (under tongue film), Zubsolv [®] (tablets), Bunavail [®] (check film), generics
Methadone	Generics
Extended-release naltrexone	Vivitrol [®] (injection)

* Other extended-release buprenorphine formulations expected to come to market

Psychosocial Treatment

- Psychosocial treatment is recommended in conjunction with any pharmacological treatment of OUD. At a minimum, psychosocial treatment should include the following: psychosocial needs assessment, supportive counseling, links to existing family supports, and referrals to community services. Examples include counseling during medication management visits, adjunctive mental health treatment, and referral to community agencies to assist with housing or food, and vocational training or education and job placement. For the typical drug court participant with high criminogenic needs and related risk factors, treatment designed to enhance intrinsic motivation, improve insight, and develop new skills is also likely to be needed.
- Treatment planning should include collaboration with qualified behavioral health care providers to determine the optimal type and intensity of psychosocial treatment and for renegotiation of the treatment plan for circumstances in which participants do not adhere to recommended plans for, or referrals to, psychosocial treatment.

Linking Participants to MAT

- Many drug courts rely on their treatment team members or local substance use disorder treatment programs to determine whether medication is indicated and to identify qualified medical practitioners.
- However, many treatment programs do not have physicians and nurses on staff and may have limited access to or familiarity with medication. In some cases, programs may even be biased against medication. Nonetheless, in order to effectively provide services to drug court participants, drug court clinicians must develop the ability to connect participants with programs and professionals who administer medication.
- 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 drug court.

Finding a MAT provider:

American Society of Addiction Medicine:

community.asam.org/search

American Board of Addiction Medicine:

abam.net/find-a-doctor

American Academy of Addiction Psychiatry:

aaap.org/patient-resources/find-a-specialist

SAMHSA Buprenorphine Treatment

Physician Locator: findtreatment.samhsa.gov

SAMHSA Behavioral Health Treatment

Services Locator: samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

- Local, single-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.
- Once a clinician has been located, it is important to *link* the participant to medication, not simply *refer* a person. This includes engaging the participant in understanding and consenting to medication and ensuring continuity of care by use of case and care managers, recovery coaches, peer mentors, and peer support.

Abbreviations

ASAM	American Society of Addiction Medicine
COWS	Clinical Opioid Withdrawal Scale
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
FDA	Food and Drug Administration
HIV	Human immunodeficiency virus
OBOT	Office-based Opioid Treatment
ODU	Opioid use disorder
OOWS	Objective Opioid Withdrawal Scale
OTP	Opioid Treatment Program
SOWS	Subjective Opioid Withdrawal Scale
TB	Tuberculosis
WM	Withdrawal management

Endnotes

¹ ASAM Definition of Addiction. www.asam.org/for-the-public/definition-of-addiction

² National Institute on Drug Abuse. Principles of Drug Abuse Treatment for Criminal Justice Populations. <https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles>

³ The ASAM Criteria, ASAM Public Policy Statement: Opioid Treatment Services, 2013, pp. 290 - 298.

⁴ The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine. <https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing>

⁵ National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume II. http://www.nadcp.org/sites/default/files/2014/Best%20Practice%20Standards%20Vol.%20II._0.pdf

⁶ Substance Abuse and Mental Health Services Administration (SAMHSA). Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 14-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

⁷ ASAM/The American College of Obstetricians and Gynecologists (ACOG) guidelines. <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy>

Additional Resources

- ASAM’s Website to see pocket guide evaluation and treatment figure: <https://my.guidelinecentral.com/admin/builder/img/7d1296e996f433307883cc7cf-77b2eb87818389d.png>
- “The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use” American Society of Addiction Medicine (ASAM) Pocket Guide. *The ASAM Criteria*, 2013 pp.43-53.
- Mee-Lee D, Shulman GD, Fishman MJ, and Gastfriend DR, Miller MM, eds. (2013). (*The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.*) Third Edition. Carson City, NV: The Change Companies. Appendix A, The ASAM Criteria, 2013, pp. 393-400.
- National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume I. <http://www.nadcp.org/wp-content/uploads/2018/03/Best-Practice-Standards-Vol.-I.pdf>
- National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume II. http://www.nadcp.org/sites/default/files/2014/Best%20Practice%20Standards%20Vol.%20II._0.pdf
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA, American Psychiatric Association, 2013.
- ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine.
- Free webinars and additional material about treatment at ASAM; link to the National Practice Guideline and the ASAM Criteria at ASAM.org

