

Medication- Assisted Treatment in Drug Courts Recommended Strategies

CENTER
FOR
COURT
INNOVATION



LEGAL
ACTION
CENTER

Medication- Assisted Treatment in Drug Courts Recommended Strategies

Authors

Sally Friedman
Legal Director
Legal Action Center

Kate Wagner-Goldstein
Senior Staff Attorney
Legal Action Center

This project was supported by Statewide Enhancement Grant No. 2012-DC-BX-0012 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Acknowledgements

The authors are grateful to the New York State Unified Court System and the Center for Court Innovation for the opportunity to write this resource guide for drug treatment courts that seek to incorporate medication-assisted treatment into their programs. Specifically, the authors thank Valerie Raine, Statewide Drug Court Coordinator, Kimberly Kozlowski, Project Manager for the Office of Policy and Planning, and Robert Wolf, Communications Director at the Center for Court Innovation, for their invaluable help in organizing, writing, and producing this document.

The authors appreciate the considerable time and distilled wisdom that New York's drug treatment court staff contributed to this effort. Judges, coordinators, and project directors from across the state provided a vast amount of information about the benefits and challenges of implementing medication assisted-treatment in their programs. Without their hands-on experience of working with doctors, providers, and drug court participants, this document would not have been possible.

Finally, the authors are grateful for the substantial help provided by Melissa Trent, who works at the Legal Action Center as an Equal Justice Works Fellow sponsored by the Friends and Family of Philip M. Stern.

About the Legal Action Center

The Legal Action Center is the only non-profit law and policy organization whose sole mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for sound public policies in these areas. The Legal Action Center's work over more than four decades has helped to vastly increase alternatives to incarceration and achieve historic sentencing reforms as well as dozens of other policies that promote a public health approach to addiction, HIV/AIDS, and the criminal justice system.

About the Center for Court Innovation

The Center for Court Innovation is a non-profit organization that seeks to help create a more effective and humane justice system by designing and implementing operating programs, performing original research, and providing reformers around the world with the tools they need to improve public safety, reduce incarceration, and enhance public trust in justice.

About the New York State Unified Court System's Office of Policy and Planning

Under the direction of New York's Chief Judge, the New York State Unified Court System serves nearly 19.5 million people. To meet this challenge, New York State has approximately 1,300 judges, 2,300 town and village judges and 15,000 non-judicial employees working in over 300 state courts and 1,300 town and village courts, spread throughout 62 counties in 13 judicial districts. The system is supported by the Office of Court Administration. As the policy-making body of the Office of Court Administration, the Office of Policy and Planning works with judges statewide to study and develop new strategies to improve the delivery of justice in New York. In addition, the Office of Policy and Planning provides guidance, support, and comprehensive training programs to problem-solving courts statewide.

Contents

Authors and Acknowledgements	ii
Introduction	1
I. Medication-Assisted Treatment	6
II. Nine Components of Successful MAT Programs	12
III. Court Profiles	17
Central New York Treatment Court	18
Serving a mid-size city and nearby suburban and rural areas.	
Upstate Treatment Court	29
Serving a small city and the surrounding suburban and rural areas.	
Downstate Urban Treatment Court	38
Serving a densely populated county within a large city.	
IV. Specific Issues for Rural Courts	45
Conclusion	48
Endnotes	50
Appendices	54

Introduction

....BE IT RESOLVED THAT:

1. Drug Court professionals have an affirmative obligation to learn about current research findings related to the safety and efficacy of M.A.T for addiction.

2. Drug Court programs should make reasonable efforts to attain reliable expert consultation on the appropriate use of M.A.T. for their participants....

3. Drug courts do not impose blanket prohibitions against the use of M.A.T. for their participants. The decision whether or not to allow the use of M.A.T. is based on a particularized assessment in each case of the needs of the participants and the interests of the public and the administration of justice.

*—National Association of Drug Court Professionals
Resolution of the Board of Directors*

Introduction

This report is designed to help drug court practitioners understand medication-assisted treatment (MAT) for opioid addiction and to provide strategies for incorporating MAT into their practice. The report's information about different MAT models can serve as a resource for courts that currently permit MAT as well as those considering it. Though based on the experience of courts in New York State, the report's recommendations are not state specific and can be applied to courts around the country.

MAT involves the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. When used to treat opioid addiction, MAT stabilizes brain chemistry, blocks the euphoric effects of opioids (the “high”), relieves physiological cravings, and normalizes body functions. Numerous studies have shown that MAT reduces illicit drug use, disease rates, overdose, mortality, and criminal behavior.

With the opioid epidemic ravaging communities across the country, there has been an increasing call by the government, families, public health officials, and others to use all tools available to treat opioid addiction and save lives. In September 2015, New York's governor signed a law to create uniform access to MAT in the state's judicial diversion program.¹ The law amended New York's Criminal Procedure Law to explicitly state that judicial diversion programs may include “medically prescribed drug treatments” for opioid abuse or dependence and that participation in such treatment cannot be the basis for finding that a defendant has violated release conditions.²

Strictly speaking, the new provisions apply only to cases processed under Article 216—the judicial diversion program for individuals charged with certain felony offenses. Nevertheless, the legislative history evidences the unequivocal intent to promote the use of MAT in drug treatment courts when prescribed by an authorized and qualified physician:

[T]he World Health Organization has come out strongly in support of continued use of such treatments, stating that clinical research has proven that arbitrary limits on the use of methadone and buprenorphine therapy treatments is disadvantageous to the ultimate goals of judicial drug treatment programs. . . . While the legislature has the utmost respect for judicial discretion, it is evident that prohibiting the use of methadone and buprenorphine therapy treatment, or requiring its use ... merely as a ‘bridge to abstinence’ is contrary to established best practices, and hinders the recovery process.³

Additionally the United States Department of Justice’s Bureau of Justice Assistance and Substance Abuse and Mental Health Services Administration recently began requiring that all drug courts receiving federal money permit MAT. The 2015 Best Practices Standards Report issued by the National Association for Drug Court Professionals also recommends that courts grant access to addiction medications when recommended by a physician (see Appendix B). Finally, prohibition of MAT can violate federal anti-discrimination law protecting individuals with disabilities.⁴

Nevertheless, surveys reveal that only about half of the drug courts in the United States permit participants to enroll in and be maintained on MAT.⁵ Reasons for denying access to MAT range from lack of knowledge about the science of opioid addiction and the effectiveness of MAT, to the belief that taking MAT is “substituting one addiction for another,” as well as concerns about the practical implications of MAT within the drug court model.

The New York State Office of Court Administration held a training series about MAT in 2014 and many participants had questions such as: How can courts minimize illicit diversion of MAT medications? How can they successfully monitor participants? How can they address opposition to MAT by some members of the drug court team?

This report answers these and related questions while giving courts the tools to comply with recent mandates and public health imperatives so that they can improve participant outcomes by including MAT—when prescribed by a physician—as a standard treatment option for participants with opioid addictions.

This report does not suggest that MAT is appropriate for every opioid-addicted individual. It does recommend, however, that courts make decisions about MAT individually, based on objective medical evidence.

A Close Look at 10 Courts

The Legal Action Center, working closely with the Office of Court Administration and the Center for Court Innovation, produced this report based on in-depth interviews with 10 New York State drug courts, site visits to three of those courts, and a review of existing research.

The authors chose these 10 courts because they permit participants to use all three FDA-approved medications for opioid addiction and do not require individuals to stop taking their medications against medical advice. They also represent a cross section of courts based on geography and size. After interviewing these 10 courts, the authors selected three for in-depth profiles. The three reflect different regions from around New York, including urban, suburban and rural communities. They also reflect a variety of participant demographics, sizes, resources, and availability of different types of addiction medication.

Section I of this report provides an overview of medication-assisted treatment, including recent scientific research. It describes the medications and how they work, and addresses some common questions and concerns about MAT. Section II describes nine components of effective drug treatment program, as gleaned from interviews and site visits with drug courts around the state.

Section III offers in-depth profiles of three courts. The selected courts provide a range of perspectives and practices regarding the use of MAT. The courts are not named or specifically identified. However, readers interested in speaking with representatives of the profiled courts can contact the Office of Court Administration at ProblemSolving@nycourts.gov.

Section IV discusses special issues rural courts may encounter. Finally, the Appendices contain additional information about MAT, including a chart comparing MAT medications (Appendix A), myths and facts (Appendix C), an article about MAT (Appendix D), and a list of further resources (Appendix E).

I. Medication- Assisted Treatment

What is Medication-Assisted Treatment?

Medication-assisted treatment is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders, including opioid addiction.⁶ MAT operates to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and stabilize body functions without the negative effects of the short-acting drugs of abuse.

Three medications are currently approved by the FDA to treat addiction to short-acting opioids, such as heroin, morphine, and codeine, as well as synthetic opioids, including oxycodone, OxyContin®, and hydrocodone. The three are methadone, buprenorphine/naloxone (Suboxone, which for purposes of this report is referred to as “buprenorphine”), and long-acting injectable naltrexone (with the brand name of Vivitrol). A chart with information about the three medications is in Appendix A.

Methadone

Methadone is an agonist that works by reducing or extinguishing cravings for opioids, allowing the patient to function without the major physiological components of opioid disorder.⁷ When used as an addiction medication, methadone can only be dispensed in an opioid treatment program. Opioid treatment programs are any treatment program certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) in conformance with 42 Code of Federal Regulations (C.F.R.), Part 8, to provide supervised assessment and medication-assisted treatment for patients who are opioid addicted. An opioid treatment program can exist in a number of levels of care and settings, including, but not limited to, intensive outpatient, residential, and hospital settings. When used as an addiction medication, methadone is typically given in liquid form as a daily dose taken under observation.

Buprenorphine

Buprenorphine is a partial agonist which functions similarly to methadone but has a lower maximal effect than a full agonist like methadone. Maintenance on methadone or buprenorphine produces no euphoria, intoxication, or

withdrawal symptoms. Buprenorphine is almost always combined with naloxone to deter abuse; the naloxone induces withdrawal symptoms if the medication is misused by being injected. Buprenorphine combined with naloxone is sold under the brand name Suboxone. Buprenorphine can also be dispensed in an opioid treatment program, or it can be provided by a physician who meets established qualifications to provide office-based treatment for opioid addiction.

Individuals typically take buprenorphine at home in the form of a sublingual film, often referred to as a “strip.” Currently, federal regulations limit the number of patients a physician can treat with buprenorphine at one time: 30 patients the first year, 100 patients in year two and 275 in subsequent years. In September 2015, SAMHSA announced that it would be changing the regulations to expand the availability of treatment with buprenorphine.

Naltrexone

Naltrexone is an opioid antagonist which operates by blocking the effects of opioids so patients will not experience a high from using opioids. People who are dependent on opioids must stop their drug use at least seven days prior to starting naltrexone. Naltrexone to treat opioid dependence is usually delivered in the form of a monthly injection by a physician. Individuals can receive naltrexone in many settings, including doctors’ offices, opioid treatment programs, and other drug treatment settings.

Is MAT effective?

Dozens of studies have shown that medication-assisted treatment reduces drug use, disease rates, overdose deaths, and criminal activity among opioid addicted persons.⁸ According to the National Institutes of Health, “The safety and efficacy of narcotic agonist (methadone) maintenance treatment has been unequivocally established.” Research demonstrates that MAT patients experience dramatic improvements while in treatment and for several years following, including decreases in narcotic use, drug dealing, and other criminal behavior as well as increases in marriage and employment.⁹ One study found a 50 percent reduction in fatal overdoses among people receiving methadone

or buprenorphine as part of their treatment.¹⁰ Another showed a 75 percent decrease in illicit opioid use among those receiving buprenorphine and counseling for one year, compared with those who received buprenorphine for only six days, followed by counseling.¹¹

MAT's critical benefits for people involved in the criminal justice system are also well established. Drug overdose is the leading cause of death for individuals reentering society after incarceration.¹² Numerous studies show MAT reduces drug overdose deaths, recidivism, and infectious disease among criminal justice involved persons.¹³ For example, one study showed that people receiving methadone maintenance treatment with counseling in a Baltimore prison and continuing it upon release reported half the rate of illicit opioid use compared to those who received only counseling.¹⁴ They also were almost three times less likely to spend time in jail or prison.¹⁵ Another study showed that the use of injectable naltrexone in a New York City jail decreased illicit opioid use by more than 50 percent following release.¹⁶

Does MAT “substitute one drug for another”?

Though two of the three MAT medications (methadone and buprenorphine) are opioid-based, they are fundamentally different from short-acting opioids such as heroin and prescription painkillers. The latter travel directly to the brain and narcotize the individual, causing sedation and the euphoria known as a “high.” In contrast, methadone and buprenorphine, when properly prescribed and utilized, reduce drug cravings and prevent relapse without causing a “high.”¹⁷ They help patients disengage from drug seeking and related criminal behavior and become more receptive to behavioral treatments.¹⁸ Injectable naltrexone is not opioid based and does not result in physical dependence.¹⁹

How is the appropriate dose determined?

For methadone and buprenorphine, a certified health care professional determines the appropriate dose, in consultation with the patient, and calibrates the dose to the individual's medical and physiological needs. Once individuals are stabilized on the appropriate dose, they may be maintained on that dose for as long as medically necessary, as is the case with other

medications for chronic health conditions. For injectable naltrexone, the dose is standard and generally is delivered every four weeks.²⁰

People unfamiliar with the science of MAT sometimes question why an individual is taking what they perceive as a high dose of methadone or buprenorphine. Dosing, however, is an individualized medical decision. For example, most patients require a methadone dose of 60-120 milligrams per day; studies show that patients on higher doses stay in treatment longer and use less heroin and other drugs than those on lower doses.²¹ Pre-conceived beliefs, without scientific basis, that lower doses are preferable, detract from the potential value of MAT.²²

How long should someone receive MAT?

There is no one-size-fits-all duration for MAT. The Substance Abuse and Mental Health Services Administration recommends a “phased approach,” beginning with stabilization (withdrawal management, assessment, medication induction, and psychosocial counseling), and moving to a middle phase that emphasizes medication maintenance and deeper work in counseling. The third phase is “ongoing rehabilitation,” when the patient and provider can choose to taper off medication or pursue longer term maintenance, depending on the patient’s needs.²³ For some patients, MAT could be indefinite.²⁴ The National Institute on Drug Abuse (“NIDA”) describes addiction medications as an “essential component of an ongoing treatment plan” to enable individuals to “take control of their health and their lives.”²⁵ For methadone maintenance, twelve months of treatment is the minimum, according to NIDA.²⁶

Long-term medication may be beneficial. Dr. Nora Volkow, Director of NIDA, explains:

Medications can be helpful in [the] detoxification stage, easing craving and other physical symptoms that can often trigger a relapse episode. However, this is just the first step in treatment. Medications have also become an essential component of an ongoing treatment plan, enabling opioid-addicted persons to regain control of their health and their lives.²⁷

Are there risks to requiring someone to taper from MAT?

Requiring people to stop taking their addiction medications before their provider recommends it is counter-productive and increases the risk of relapse.²⁸ Furthermore, because tolerance to opioids fades rapidly, one episode of opioid misuse after full withdrawal can result in life-threatening or deadly overdose.²⁹

How much does MAT cost, and is it covered by Medicaid and other insurance?

MAT medications and treatment vary significantly in price, depending on the medication, setting, other services provided, and availability of discounts, such as a sliding scale. Methadone generally costs about \$80 per week, for medication and all other services, but many opioid treatment programs provide a sliding scale. Buprenorphine and naltrexone cost more, but prices also vary greatly. New York's Medicaid program fully covers all three MAT medications. Naltrexone has not been as widely available as the other two medications, largely due to the higher price and reimbursement mechanism for injectable naltrexone. But with the roll out of Medicaid managed care for substance use treatment in New York, reimbursement mechanisms are changing. Until recently, New York's Medicaid plan required physicians to buy naltrexone upfront and then seek reimbursement, which had the effect of limiting the medication's availability. With changing rules under Medicaid managed care, physicians may find it more financially viable to prescribe naltrexone.

Most private insurance plans in New York also cover all three MAT medications, but some impose limits, such as on the duration of use. Some private plans also require physicians to buy naltrexone and then seek reimbursement, but with the Medicaid shift described above, many private plans may follow suit because they operate both private and Medicaid plans.

Where can I get more information?

Much of the information in this section is based on the Myths and Facts Sheet in Appendix C. Appendix E lists additional resources.

II. Nine Components of Successful MAT Programs

Nine Components of Successful MAT Programs

Interviews with ten drug courts throughout New York revealed these key features of effective MAT programs.

1. Counseling and other services—plus medication—are essential.

Courts require medication-assisted treatment participants to receive counseling and wraparound services from a licensed treatment provider in addition to medication. These services are no different from those provided to participants not receiving MAT.

2. Courts are selective about treatment programs and private prescribing physicians.

In New York, courts require participants to obtain an assessment at one or more designated licensed treatment programs. When MAT is recommended, the courts generally prefer that MAT medication and other services be provided by a program licensed by the New York State Office of Alcoholism and Substance Abuse Services, usually on a court-provided list. However, participants receiving buprenorphine sometimes receive the medication from an office-based physician, most commonly if the licensed treatment programs have reached their federally mandated buprenorphine cap at one time (currently 30 patients the first year; 100 patients in year two and 275 thereafter). Courts also permit participants to receive injectable naltrexone from private doctors because they inject the medication monthly, which addresses concerns about diversion. With all forms of MAT, participants still must receive counseling and other services from a licensed treatment program. If a court finds that a provider does not meet the court's standards, it typically does not permit future participants to use that provider.

3. Courts develop strong relationships with treatment programs and require regular communication regarding participant progress.

Trust and communication are essential. Courts with successful MAT programs

maintain frequent contact with treatment providers. They expect honest and accurate reports, as well as follow-through. If providers do not communicate sufficiently, courts stop referring participants and select other providers. The consensus among the 10 courts interviewed is that licensed treatment programs generally are more reliable communicators than private physicians.

4. Screening and assessment must consider all clinically appropriate forms of treatment.

Court staff conducts the initial screening and refers to programs who conduct a complete assessment. Clinical staff within the court and in partner treatment programs used as referrals must be open to all clinically appropriate modalities, including MAT. In New York, the Office of Alcoholism and Substance Abuse Service's recent release of the LOCADTR 3 tool for determining level of care will facilitate the use of evidence-based treatment.³⁰

5. Judges rely heavily on the clinical judgment of treatment providers as well as the court's own clinical staff.

Judges understand that treatment professionals have the expertise to make treatment decisions, that such decisions should be evidence based, and that courts should not withhold appropriate medical treatment as a sanction. Practices vary as to the amount of input court clinical staff have with outside treatment providers. Some court staff share their views more actively with providers while others defer to the provider's judgement.

6. Endorsement of medication-assisted treatment by all members of the drug court team is the goal, but not a prerequisite.

All courts agreed that the program works best when all members of the drug court team support MAT. Indeed, those courts that had buy-in from the whole team evinced a more positive view of their own programs. But even in courts where key players (e.g., a judge or district attorney) have reservations about addiction medication, MAT programs can succeed as long as the team views

clinical decisions as the province of clinicians. Education about MAT, whether provided by the state or other sources, is critical in getting all team members on the same page about MAT. For some courts, the decision to allow MAT resulted from active discussion among drug court team members. In other courts, team members responsible for treatment recommendations simply started using it without much fanfare. Those team members who had resisted MAT acclimated, as the inclusion of MAT generally turned out to be relatively simple and occurred without significant changes to court practice.

7. Monitoring for illicit use of medication-assisted treatment medication is a key component of the program and can be accomplished in different ways.

Courts use a range of methods, such as urine tests, pill/strip counting, and behavioral observations to detect misuse or abuse of medication. These methods generally are not that different from those used to monitor illicit drug use by other non-MAT participants. Some courts do more of the monitoring themselves, while others may rely primarily on treatment programs with which they communicate regularly.

The method and extent of monitoring also depend on the type of medication. Buprenorphine patients typically take home a month's worth of medication, which requires more vigilant monitoring. Methadone patients, on the other hand, typically take their dose under observation by the provider (in liquid doses at the clinic) so cannot misuse their medication as easily. Naltrexone is generally injected by a physician, and therefore, viewed as the least divertible medication. All courts acknowledge that there is some illicit diversion of MAT medication (mainly buprenorphine), but see it as something that they can manage and that does not justify a blanket prohibition. Many practitioners note that illicit use of medication occurs among opioid addicted people who are not enrolled in MAT programs and who often use MAT medication illicitly to self-medicate; such misuse might decrease with more access to MAT.

8. Medications for medication-assisted treatment are covered through government and/or private insurance programs.

Medicaid or other insurance programs generally pay for participants' treatment, especially in the initial stages of drug treatment court. When participants begin working, coverage can become more challenging. Courts try to help participants access appropriate coverage, but are not always successful. For those who need to self-pay, methadone is much less expensive than buprenorphine and naltrexone.

9. Medication-assisted treatment operates very similarly to other kinds of treatment.

Courts repeatedly emphasized that they did not do things very differently for MAT participants. Some courts conduct identical urine testing for MAT and other participants, while other courts add methadone and buprenorphine tests for MAT participants only. A few courts also count buprenorphine strips. Thus, many of the key components noted above are also essential for other parts of the treatment court's operation.

III. Court Profiles

Central New York Treatment Court

Jurisdiction: Mid-size city and nearby suburban and rural areas

Overview

This court has been operating since 1997 in a county with a population of about 500,000. The county includes a mid-sized city, its suburbs, and rural areas. The court's docket averages 250 cases. In addition to the judge, the court has a staff of six: project director, resource coordinator, and four case managers. Other members of the drug court team include a probation officer, prosecutor, assigned counsel, and representatives from treatment programs and a vocational rehabilitation program. Eligible offenses include both drug and non-drug, non-violent felony and misdemeanor offenses that can be processed either before or after a guilty plea. Upon successful completion of misdemeanor cases, charges are dismissed and sealed. For felony cases, the court takes a misdemeanor plea and sentences the offender to a conditional discharge.

About 70 percent of the court's participants have an opioid addiction, and nearly all of them receive MAT. In 2015, about 74 percent of participants were white, non-Latino/a; about 20 percent were African-American; roughly three percent were Latino/a; and less than one percent were other races and ethnicities. About two-thirds were male and one-third were female.

Which opioid treatment does the court use?

The court permits participants to receive all current MAT medications and requires all participants to receive counseling and other supportive services from a state-licensed treatment program. The court does not permit any participants to receive addiction medication without these additional services.

The court maintains a list of approved providers, based on criteria such as effective communication, monitoring, and follow-through. The court has excellent relationships with providers on this list—a vital element to the program's success. The court, not the participants, chooses the MAT treatment provider, as it does for other forms of treatment. The type of MAT participants use breaks down as follows:

Methadone: Currently, only a few participants receive methadone maintenance treatment because the county has only one opioid treatment program with typical waiting lists of several months.

Buprenorphine: Nearly all participants currently receive buprenorphine because it is the most available. The court’s list of approved providers evolves based on the court’s experiences with individual providers. For example, providers who communicate effectively and cooperate with the court remain on the list; those who do not are removed. All participants receive the medication at outpatient programs designated by the court. Those who live in a half-way house give the medication to the manager, who distributes it at a set time. A small number receive it through office-based physicians on the court-approved list (which excludes physicians who accept cash only), but only if the outpatient program treating the client has reached its buprenorphine cap. Any such participant must attend the outpatient program for counseling and other services.

Naltrexone: Very few participants receive naltrexone because most treatment programs do not offer it, and there is limited availability among private physicians. (Read more in Section I).

Who makes treatment decisions?

Members of the drug court team are united in their view that clinical staff should make treatment decisions. As the prosecutor says, “I’m not a treatment provider or doctor. How can I say ‘you don’t need MAT?’” Case managers say they “guide” the participants, but treatment programs “lead.”

“I’m not a treatment provider or doctor. How can I say ‘you don’t need MAT?’”

—Prosecutor

Prospective drug treatment court participants receive a substance use disorder assessment and psychosocial evaluation by a credentialed case manager, who uses a standard assessment tool. The court then refers individuals

to a state-licensed treatment program for a more in-depth assessment.

Most prospective participants are not receiving MAT or any other treatment at the time they enter drug treatment court, but many express a desire to enroll in MAT. “Some individuals really believe they need something or they will use,” according to the probation officer assigned to the court. The court’s clinical staff sometimes provides input about whether a participant should receive MAT, and expects to collaborate with the treatment providers to agree on an appropriate treatment plan.

Many individuals entering drug court report prior use of buprenorphine or methadone. Some have used MAT in treatment programs and some admit to prior illicit use (mainly of buprenorphine). Some participants admit to diverting their medication. While the court does not condone illicit use, neither does it deny access to buprenorphine through a licensed treatment program solely because of prior illicit use. The court works to get participants a legitimate prescription to aid in recovery.

What services does the court require in addition to MAT medication?

The court requires all MAT participants to receive counseling and the full array of other services provided by the court and community-based programs. For example, the court’s case managers help participants access mental health and medical care, housing, child care, employment, and obtain essential documents, such as birth certificates and social security numbers. All of the programs provide individual and group counseling, physical and psychological examinations and evaluation, and other supportive services.

Drug court team members and treatment providers all emphasize that MAT is more than medication. Counseling is critical—and required—though the frequency generally decreases as the patient progresses in treatment. The court uses the same approach for participants not receiving medication. The probation officer notes the complementary nature of medication and counseling: “Participants generally need medication to address the physical dependence. With medication, they do not need to think about using all day long and can focus on their recovery.”

How long do participants stay on medication-assisted treatment? Who decides?

As with other treatment decisions, the physician and treatment provider, in consultation with the patient, make decisions about duration of MAT. The court does not require or encourage people to titrate down. Some individuals want to taper and stop MAT ultimately, but the court encourages them to discuss these issues with their treatment provider.

The court sees some advantages to a longer course of MAT. Prolonged treatment with medication means the patient will have regular contact with a physician, which the court views as a plus. “Even if they graduate, the prescribing doctor still needs to see them. The longer participants see someone, the better chance they have of staying out of the system,” says the court’s program director. The prosecutor is hesitant to recommend that anyone taper off their medication because she has observed people relapsing while tapering off their recommended dose.

How does the court monitor compliance and illicit use of medication?

The court’s strategies to monitor and encourage compliance are similar to those used for all drug court participants. Monitoring MAT participants does not require substantial extra work or expense.

Treatment programs do the lion’s share of monitoring and are in regular communication with the court. When participants complete the counseling portion of their treatment, monitoring shifts more to the court. Key components of monitoring include the following:

1. Close monitoring of MAT medications.

Court team members agree that buprenorphine has the greatest potential for misuse because patients take it home. Methadone is rarely diverted illicitly because it is dispensed daily in liquid form (with limited take home privileges) and clinic staff directly observes ingestion. Most methadone sold on the streets is the pill form, prescribed for pain. Naltrexone cannot be abused. It is

an antagonist medication, not an opioid, and typically is injected monthly by a physician.

Following are the court's strategies to prevent and monitor illicit use of MAT medication or drugs generally. Each strategy complements the other; none is used in isolation:

a. [Urine testing](#)

Who tests and how? Treatment programs do most of the urine testing in the earlier stages of participation, and the court takes on a greater role after participants complete treatment, but are still enrolled in drug court. The probation officer also conducts weekly testing for participants on probation. The court conducts random testing during court appearances, as well as by assigning colors and calling individuals with certain colors to come in for testing.

Does anyone test for levels of MAT medication? None of the court, probation, or treatment programs tests for the specific level of MAT medication (i.e., to ensure that participants are taking their full dose, rather than diverting it), and such tests may not be reliable. Moreover, they do not view that level of testing as necessary. They believe that other methods, such as urine testing and those described below, sufficiently address illicit use.

b. [Pill and strip counting.](#)

Who counts and how? If there is suspected misuse, the court counts buprenorphine pills and strips. For those participants under probation supervision, the probation officer counts pills and strips only for participants not living in halfway houses. (Halfway houses keep the buprenorphine strips securely stored and distribute it daily.) Program practices vary, with some engaging in regular random counting and others only counting if they suspect misuse.

What if participants sell and buy strips? Each buprenorphine strip has a number. Some programs photocopy the strips before distributing them to patients and then match the returned strips with the copies.

Is pill and strip counting a burden? None of the drug court team members considered it time consuming or otherwise onerous.

c. [I-STOP—prescription drug monitoring program.](#)

Checking I-STOP, New York’s prescription drug monitoring program, is another tool to detect illicit use of buprenorphine. I-STOP is a program established by the New York State Department of Health, requiring prescribers/dispensers of Schedule II, III, and IV controlled substances to check an online registry for such prescriptions over the past six months. One participant’s treatment program checked I-STOP and learned that the patient had obtained buprenorphine from a physician in New York City while also receiving it from the central New York prescriber.

d. [Observation.](#)

Court personnel, probation, and treatment programs all observe participants’ behavior and appearance. Are participants appearing for court and probation appointments? How do they look and feel? Do they appear “high?” Appearance alone would not be the basis for a sanction, but it might trigger an investigation. Similarly, physicians who observe positive urines or missed groups investigate for illicit use or diversion of medication. One program physician commented that by developing strong therapeutic relationships with patients, he generally can detect when they are not truthful.

The judge relies mainly on reports from treatment programs but also makes his own observations and listen to participants. Does the participant seem to be truthful? Does s/he report the same information to the judge, case manager, and treatment counselor? Or do explanations continually change?

2. [Excellent communication with treatment programs.](#)

All members of the drug court team cite the excellent communication with

programs as a major reason for the success of the MAT program and the drug treatment court generally. Communication aids in monitoring medication use (and misuse) and progress in treatment generally, while also enabling the players to address issues as they arise. Highlights of the court's communication with treatment providers are as follows:

a. Use of multiple forms of communication.

Programs and the drug court team communicate through email, phone calls, and meetings in court (program staff sometimes attend court staff meetings), in addition to formal weekly written reports. Treatment programs assign one staff member to appear at every court date in case the court has questions.

b. Communication early and often with a problem-solving approach.

Programs generally notify the court as problems arise so they can be addressed. "They call us right away," notes a case manager. The judge explains that sometimes a treatment program notifies the court about a problem that the program is addressing but does not yet want discussed in court. The judge honors that request, but is glad to know about the issue. Communication is not limited to objective data, such as attendance and urine screens, but includes discussion of behavior and other issues that court staff and treatment professionals can address jointly.

Communication is not always flawless. Some court staff report occasional frustration with programs not returning calls in a timely manner and not providing information upfront. In some instances, the court has discontinued making referrals to programs because of poor communication. However, generally, the quality of communication was deemed excellent.

How does the court respond to non-compliance and relapse?

The court uses a variety of tools to address non-compliance. Responses include increased counseling and services, a higher level of treatment, more court visits, warnings, and jail time. The judge places a high value on honesty and effort. Therefore, individuals who lie and fail to appear at appointments are likely

to receive a harsher sanction than those who are forthcoming about relapse, especially early in treatment. The court, however, does not order people to

What resources does a drug court need to incorporate MAT? According to one case manager, just “a phone, a treatment provider, and a doctor. Invite these people into a room for a meeting. It’s not that difficult.”

discontinue MAT if they relapse. The court relies heavily on the treatment program’s recommendation concerning continued use of MAT.

What are the consequences for sale of MAT medications?

Participants who sell their MAT medication receive an

immediate sanction of jail time, which is the same sanction received by non-MAT participants who sell drugs illegally. Any decision about the individual’s continued participation in MAT is made in consultation with the physician and/or treatment program.

Is illicit diversion of MAT medications common?

No. Drug treatment court team members say that most participants truly want to succeed and do not divert their medication. “Most participants are so grateful to get Suboxone that they don’t want to mess it up,” explains one team member. A treatment provider notes that “patients value their medication more than some people think. People tend to focus on those who are not doing well as opposed to those who are.”

At the same time, drug court team members know that some illegal diversion of MAT medication (mainly buprenorphine) occurs despite their best efforts to prevent it. Ultimately, there is no way to stop illegal use and diversion entirely. Yet they believe the pros of using MAT far outweigh the cons of some diversion. The prosecutor sums it up this way: “MAT is definitely successful. Suboxone will end up on the street... [whether or not the court permits it]. But you will have more success in your community if you allow all the tools that work.”

Does allowing medication-assisted treatment create a burden and cost for the court?

The general feeling within the drug court team is that incorporating MAT is not a burden. The only additional cost is the minimal expenditure for the drug tests that identify buprenorphine and methadone. What resources does a drug court need to incorporate MAT? According to one case manager, just “a phone, a treatment provider, and a doctor. Invite these people into a room for a meeting. It’s not that difficult.”

The probation officer finds that supervising individuals on MAT is no more challenging than supervising anyone else. “If anything, they are more compliant because they have a doctor and counseling.”

Who pays for medication-assisted treatment?

Most participants cover MAT costs through Medicaid, which, in New York, covers methadone, buprenorphine, and naltrexone. A small number have private insurance. When participants transition to employment, the court’s case managers help them obtain new coverage if they do not retain Medicaid eligibility. Some do retain Medicaid because they earn below the threshold. Others access insurance through the New York State Exchange, though some cannot afford the subsidized premiums. Some obtain insurance through their employers or family members. Those who cannot afford or access any form of insurance try to self-pay, but also get assistance from a variety of sources. For example, pharmaceutical companies provide coupons, and the opioid treatment program has a sliding scale. There is also a generic version of buprenorphine that brings down the price.

What challenges does medication-assisted treatment pose?

Drug court team members do not view any challenge as unsurmountable, but some challenges other than those already noted include:

- Insufficient treatment capacity for all three MAT medications, which can lead to heavy reliance on buprenorphine (though it, too, is limited). For

more information, read the discussion in Section I about the availability and cost of MAT.

- Lack of family support. Some participants face resistance and stigma from family members, generally due to a lack of information about MAT. To overcome this challenge, case managers do their best to educate family members. Sometimes they do not succeed until the participant has relapsed without MAT.
- Stigma against MAT at many 12-step programs. Clients can face hostility to MAT at 12-step meetings and consequently may choose not to disclose their MAT participation. To address this challenge, case managers provide information about 12-step meetings with a reputation for more openness to MAT. They report that this problem has diminished over time.
- Limited MAT at the local jail. When serving a jail sanction, individuals can receive methadone, but not buprenorphine or naltrexone. Moreover, no MAT is available for people who are sentenced, except for pregnant women. Individuals on methadone at the time of sentencing must titrate down. If people are sentenced while on buprenorphine or naltrexone, jail staff treats them for withdrawal.

How did this court's MAT program begin?

The court incorporated MAT during its inception in 1997. The judge and coordinator were both in favor of providing access to methadone maintenance treatment, and there was no opposition by other key players. As each new MAT medication has been developed, the court has incorporated it to the extent that it is available. The court works to educate its staff and other drug court team members through trainings offered by the state licensing authority and court system.

How do court personnel view medication-assisted treatment?

While no one has formally studied the effects of MAT on participants' success, the overwhelming sentiment of drug court team members is that MAT is a highly effective component of their court and is crucial in addressing the opioid

“Not using MAT is like repairing a car without a wrench,” says the judge.

epidemic. “Not using MAT is like repairing a car without a wrench,” says the judge. Courts need to use all available tools to treat opioid addiction.

The program is “great,” according to the probation

officer. “Several clients were successful on MAT and would not have been otherwise.” Case managers deem it “absolutely successful.” In their day-to-day experience, they see behavioral differences between participants who are and are not in MAT. They find that participants who are in MAT tend to be more goal-oriented and stick to their plans; the court can retain them. Staff has seen participants succeed without MAT, but think that most do not. In most cases, participants who do not use MAT continue to use opioids illegally, do not appear for treatment and court dates, buy buprenorphine on the street, and then detox in jail.

Upstate Treatment Court

Jurisdiction: Small city and the surrounding suburban and rural areas.

Overview

This small court serves a county with a population of about 160,000. Though the court is located in the city, many of its participants live in the surrounding rural and suburban areas. It has operated since the mid-1990s. The court has a docket of approximately 25 participants. Its full-time staff consists of one resource coordinator, but it has support from a large team which meets every two weeks. Members of the drug treatment court team include the judge, the court clerk, the substance use counselor from the Department of Social Services, and representatives from the District Attorney's Office, Public Defender's Office, probation, and the local jail.

Eligible offenses include misdemeanors, except domestic violence with intimate partners, sex offenses, arson, or violent offenses. Court participants have entered pleas with their sentences deferred until program completion. Upon successful completion of drug court, their pleas are almost always withdrawn and reduced to a six-month adjournment in contemplation of dismissal.

Approximately 75 percent of participants have an opioid addiction, and about half of those receive MAT. Between a third and a half of the participants who receive MAT have had previous experience with it. The court does not capture demographic information about participants but estimates that most are Caucasian, about 10 percent are African-American, and 5 percent are Latino/a. The percentage of men and women fluctuates.

Which Opioid Treatment Does the Court Use?

The court permits participants to receive any of the available addiction medications while also receiving counseling and other services from a state-licensed treatment program. The court does not permit any participant to receive addiction medication without these additional services.

Based on the level of care determination, the resource coordinator usually gives participants a list of programs that can provide the appropriate treatment

modality and lets participants select the program they think will work best based on schedule, location, or other needs.

The court does not make recommendations about MAT. If participants tell the resource coordinator that they are interested in MAT, she tells them to talk to the treatment program about it at their assessment. The selected treatment program determines whether someone will receive MAT based on its more detailed assessment. Prior misuse of an addiction medication does not prevent someone from accessing medication to support treatment. Almost all of the participants with opioid addiction have at some point misused buprenorphine, but when they receive it as medication with proper monitoring, the court finds they are unlikely to misuse it.

The type of MAT participants receive breaks down as follows:

Methadone: Currently, only two pregnant participants receive methadone maintenance treatment. There are only two methadone programs within a 200-mile radius, making access difficult. In addition, participants in methadone maintenance face particularly strong stigma in the community.

Buprenorphine: Nearly all participants on MAT receive buprenorphine because it is the most available. About 85 percent receive it from their treatment programs. The few participants who receive buprenorphine from private doctors already were being treated by them before they came into drug court, or attend the local treatment program that does not provide MAT. If a participant needs to find a private doctor, the treatment court provides them with a list of approved doctors. If doctors do not use appropriate clinical standards (e.g., do not examine patients or conduct drug testing), the court does not allow participants to use them.

Naltrexone: No participants currently receive naltrexone because of its high price and insufficient insurance coverage. The court expects to increase use of naltrexone as changes in pricing and insurance coverage make access more feasible.

Who makes treatment decisions?

The court staff expects the treatment programs to make treatment decisions while taking into consideration the court's input. The resource coordinator reports good relationships with the local programs and thinks they see her as a support. She is able to share information with them and says the programs end up on the same page. "Usually, when we put our heads together, we find better solutions."

The court monitors MAT participants with the same strategies used for other participants, with the single addition of counting the buprenorphine strips.

At intake, the resource coordinator conducts the standard substance use disorder screening and psychosocial evaluation to determine the level of care, sometimes in consultation with the substance abuse specialist for the county's Department of Social

Services. The resource coordinator then refers participants to a state-licensed treatment program for more detailed assessments and a treatment plan with the expectation that the program will discuss its treatment plan with her. She is almost always comfortable with the plan, but if she has concerns, she raises them, as she does if issues arise during treatment.

The resource coordinator finds that programs and doctors are very responsive to her concerns. "I have collateral information that they don't have. We compare notes. When I interview people in jail they tend to be more forthcoming," she says. In one case, a participant told her about drug use that he did not report to the program. Another time, the coordinator contacted a doctor to let him know that when prescribed 30 mg. of buprenorphine, the participant was nodding off in court. The doctor decided to lower the dose. The coordinator cannot think of a time when she and the program have not been able to agree about a plan.

The resource coordinator can also be a support for the programs because she is familiar with the other agencies in the area. For example, a residential program needed to release a court participant to supportive living. The

residential program identified two possibilities, unaware of significant problems at both programs. The resource coordinator was able to identify an alternate provider that was better run and could more effectively serve the participant.

What services does the court require in addition to MAT medication?

Every participant must receive counseling whether or not they receive MAT. “MAT participants are not treated any differently from other participants,” the resource coordinator reports. Participants’ treatment programs also may refer them for additional services, including vocational counseling, mental health treatment, and trauma counseling, as needed. All participants—MAT recipients and others—receive these wraparound services.

Drug court team members convey that incorporating addiction medication does not otherwise change their approach to treatment. The judge explains, MAT is just one part of “a multi-faceted approach to maintain sobriety.” He adds, “MAT is not a panacea. It’s not like you can pop a pill and addiction is going to be resolved... You try outpatient. Is this working? Try five days instead of three days a week. Not working? Residential. You have to try various things. You have to be open to every tool that is out there.”

How does the court monitor compliance and illicit use of MAT medication?

The court monitors MAT participants with the same strategies used for other participants, with the single addition of counting the buprenorphine strips. As the assigned prosecutor says, “monitoring may be a challenge, but we have to monitor even if participants are not on medication.” The court does not feel it can rely solely on programs and doctors to thoroughly monitor participants, whether or not the participants receive MAT. Accordingly, the court develops its own protocols for monitoring compliance.

The court’s monitoring protocols include the following for all participants:

1. Urine Testing

Who tests and how? The court conducts its own random testing of all

participants at least weekly. Participants are required to call the court every weekday to find out if they need to report for random testing. The court does not rely on the programs to test because some of them seem to test on predictable days, for example, every Monday, do unobserved tests, or do not test frequently enough.

Frequency? The drug court team emphasizes the importance of testing at least weekly, sometimes more, and making sure the schedule is unpredictable. For example, the court sometimes tests someone two days in a row or even twice in one day by testing in court and then calling the program and asking them to test when the person returns. They also continue frequent testing even in the last phase of court supervision because they are concerned that people may slip as their treatment requirements decrease.

Extra testing for medication? All participants are tested for buprenorphine and methadone whether or not they receive MAT. The court wants all participants to understand that they will be tested for these medications and that the court knows how to interpret the test results. Participants know they will not be able to falsely claim that a positive test result for another illicit substance is the result of their prescription medication.

2. Parental involvement for young people

When participants under 25 years old live with their parents, the court requires that they sign a release for the court to communicate with their parents. The court then may check in with the parents about how the young person is doing at home.

3. Observation

Court personnel observe participants in court and follow up with participants who are not behaving like themselves. For example, if they are “flying off the handle,” acting jumpy, or using the bathroom five or six times during court, court staff will intensify supervision. They also find that other participants have a better sense than staff of when someone is struggling. Observing how

other participants look at a peer may give an indication that court staff should follow up with the person.

The court coordinator believes that by getting to know participants, she can more effectively identify potential issues. Court participants mentioned that it is helpful to know that the court coordinator is “there to talk to” and that she is “open-minded to maintenance treatment.” The coordinator also comments that one benefit of doing so much testing is that it is an opportunity to see the participants out of court when there is more time to talk. Observed urine testing “can be an uncomfortable situation for some participants, so I’ve learned to start chatting with them. You can get a different kind of information when you’re in this situation,” the court coordinator says.

The court coordinator could not think of an instance in which the court learned a participant was selling medication.

4. Communication with treatment providers

Communication with the treatment providers sometimes requires persistence. The resource coordinator ensures that the court ultimately gets the

information it needs, but it can require a lot of her time; it can be especially hard to stay in touch with independent doctors.

Frequency: The court usually expects weekly reports from treatment programs, though the frequency depends on the participant’s progress. When someone is struggling, the court may talk to the program multiple times in a day; if someone is doing well, it may accept reports biweekly. The court does not expect reports from independent doctors who are not connected with programs, but the coordinator calls them if an issue arises.

Method: Communication is usually by email, but some providers prefer not to communicate in writing, in which case the resource coordinator calls them.

Communication challenges: The court has encountered programs or private doctors who are hard to reach or who do not report accurately or with enough detail. For example, a program may report that everything is fine and later report that they are discharging the participant for reasons that show the original information was inaccurate. Doctors can be especially difficult to reach, sometimes even when they work in connection with a treatment program, but especially when they are solo practitioners.

Responses to communication problems: When there has been a lapse in communication with the program, cc'ing the program's clinical director—or in the case of a methadone program, the medical director—usually produces a response. If an independent practitioner is unresponsive, the court tells the participant that they need to help encourage their provider to respond, or they may not be able to continue to see that provider.

In New York, in the unusual situation that the court has extreme concerns about a provider, the court files a complaint with the Office of Alcoholism and Substance Abuse Services through the agency's liaison at the Office of Court Administration.

5. Strip counting (for MAT participants only).

In addition to the above monitoring protocols, participants who receive MAT are monitored with strip counting. The court expects programs to count the buprenorphine strips of participants who receive this medication. When participants live in community residences, they must provide their strips to the staff, which makes strip counting easy. The court also does some strip counting itself if a program does not follow strict protocols.

How does the court respond to non-compliance and relapse?

The judge is consistent with sanctions so that participants have a sense of what to expect. The specific response may depend on factors like the person's stage of treatment and the particular behavior or relapse involved. Typically, non-compliance may lead to a higher level of care and/or increased drug testing. The

court may also respond with increased court reporting, daily check-in with the coordinator, a weekend in jail, or a combination of these sanctions.

A positive test for illicit substances or a negative test for prescribed MAT medication is considered non-compliance. In such cases, the court notifies the doctor. Sometimes, doctors give the patient a warning that if this continues, the doctor will stop prescribing the medication.

What are the sanctions for illicit sale of MAT medications?

The court coordinator could not think of an instance in which the court learned a participant was selling medication. If that happened, the court would respond with a sanction. The court also would expect the treating doctor to stop prescribing the medication based on concern about its distribution.

Is illicit diversion of MAT medications common?

No. The team has not seen diversion of MAT medications. The assigned prosecutor explains,

If they're on [MAT], most of them want to take it. They don't get it for the purpose of giving it away. I haven't seen diversion happening in this court. [The court] might miss it occasionally but not for long. ... If you're doing the monitoring you should be doing, it can only go on for so long before a flag is thrown that something is off.

The resource coordinator thinks the court may see less diversion because "the people who choose to go on [MAT] may be older and more mature." They may have already had multiple treatment attempts and feel more motivated for recovery.

The judge thinks there is minimal diversion largely due to the court's close monitoring. "I'm okay with [MAT] as long as we can monitor it," he concludes. "Lying is part of active addiction," he notes. "You need an educated treatment team and educated judge... [or] they will try to get one over on you."

Does allowing MAT create a burden and cost for the court?

Allowing MAT requires some additional time expenditure but not other concrete costs. The court may count the buprenorphine strips for MAT recipients in addition to its other monitoring and spends more time trying to reach doctors who can be slow to respond. Including MAT also requires educating the team members and the treatment community about how it works and its impact on achieving and maintaining recovery. Nonetheless, the team feels strongly that MAT is a valuable tool for some of its participants.

Who pays for MAT?

Most participants either have private insurance or Medicaid that pays for MAT. Others pay a significant amount for MAT, either in co-pays with private insurance, or through self-pay if they do not have insurance coverage. However, even these participants have been able to cover the cost of MAT, sometimes with the help of family members.

The court maintains a list of approved providers, based on criteria such as accurate progress reports, regular communication, attentive monitoring, and the quality of the therapeutic relationship with participants.

Downstate Urban Treatment Court

Jurisdiction: A densely populated county within a large city.

Overview

This large court serves a county with well over a million residents and has a docket of approximately 250 cases. The staff includes a judge, project director, resource coordinator and four case managers. Other members of the treatment court team include the assigned prosecutor and defense attorney. Eligible offenses include non-violent felony offenses to which participants have already entered pleas with their sentences deferred until program completion.

Approximately one-third of the court's participants have a history, often lengthy, of opiate addiction; heroin is almost always their drug of choice. Between 2012 and 2015, about 57 percent of participants were Latino/a, 29 percent were black/African American, 4 percent were white/non-Latino/a, 1 percent was Black/West Indian, and 9 percent were other or unknown race or ethnicity. Eighty-five percent were male, and 15 percent were female.

Which Opioid Treatment Does the Court Use?

The court permits participants to receive any of the available addiction medications, in addition to counseling and other services from a state-licensed treatment program. The court does not allow any participants to receive addiction medication without these additional services.

The court maintains a list of approved providers, based on criteria such as accurate progress reports, regular communication, attentive monitoring, and the quality of the therapeutic relationship with participants. The court avoids programs with a "punitive" mindset. The court seeks providers who offer the full range of treatment options, including medication. If a participant enters the program already working with one of the providers on the list, they can usually continue that relationship. If a participant's existing provider is not on the court-approved list, the court will refer him or her to an approved program.

A significant number of individuals entering drug court report prior illicit use of buprenorphine or methadone, but this does not necessarily bar them from receiving MAT. The court finds that effective treatment and monitoring increase

the likelihood that participants will use medication as prescribed.

About 85 to 90 percent of the MAT participants receive methadone. About 10 to 15 percent receive buprenorphine. A very small number receive Naltrexone because few programs provide it, but it is becoming increasingly available. The court refers people to programs that determine which medication would be most appropriate. It does not prefer one medication over another.

Some of the barriers to methadone encountered in other parts of the state are not present in this area; local methadone clinics do not have waitlists and are relatively close to participants' residences.

Treatment decision-making

Clinical staff at the drug court conducts the initial assessment with the standard psychosocial instrument used by all New York drug courts. Based on assessment results, staff refers the participant to an appropriate program. The program then develops the details of the person's treatment plan, including decisions about medication.

Not all members of this drug court team are confident that MAT is an appropriate treatment for opioid addiction, nor are they all familiar with the science supporting MAT. The assigned prosecutor thinks it would be better for participants not to take medication so they can break free from "the chain of addiction." She explains, however, that her role is to assess if defendants are eligible for drug treatment court based on their criminal history, not make determinations about their treatment needs. She thinks that black and white rules do not help anyone.

The judge also asserts that he is not necessarily an advocate for MAT, but that he defers to clinicians. When he was first assigned to the drug court, he spoke with doctors who had worked at treatment programs about their use of MAT. He concluded that medication could be an important tool and clinicians should have the full range of available treatments. Accordingly, the court lets clinicians determine whether to use MAT on a case-by-case basis. The judge does not weigh in on those determinations, but rather makes decisions about legal eligibility and sanctions.

Some participants have concerns about receiving MAT and may be reluctant to start it, or express an interest in tapering off. In some cases, this may be due to internalized stigma, i.e., from pressure by staff at treatment programs or

The court requires all MAT participants to receive counseling and the full array of wraparound services provided by the treatment programs.

12-step programs to taper off it.

The case management supervisor says they generally counsel:

“Slow down, it’s OK to be on MAT. Think it through.” Court staff try to communicate that MAT should not be stigmatized and can be part of meaningful recovery. They always encourage

participants to speak with their treatment providers regarding decisions about MAT to ensure that any decision is well informed. When participants want to stop taking MAT because they find it burdensome (e.g., because of the daily clinic visits for methadone, or because of the effects of the medication), the court still may suggest waiting until after graduation when they will not face legal consequences if they have difficulty tapering, as people often do.

What services does the court require in addition to MAT medication?

The court requires all MAT participants to receive counseling and the full array of wraparound services provided by the treatment programs. The court’s expectations for MAT participants are the same as for participants who do not receive medication.

How long do participants stay on MAT?

The length of treatment is based on an individual clinical determination. The court does not expect participants to stop MAT in order to graduate from the program. Early on, the court required people to taper off MAT and stay off for 60 days. They saw a pattern of participants coming very close to graduation, but then having multiple relapses. The court then would order six more months of treatment, and the cycle often repeated. One-year mandates turned into two-,

three-, or four-year mandates, or sometimes failure and a long prison sentence. Once the court allowed people to continue with MAT through graduation, participants were much more successful.

How does the court monitor compliance and illicit use of MAT medication?

The court expects the treatment programs to take the lead on monitoring participants' compliance. Like the other profiled courts, this court's strategies to monitor and encourage compliance are similar to those used for all drug court participants. Key components of monitoring include the following and generally apply to all participants, whether or not they receive MAT:

1. [Urine testing](#)

Who tests and how? The court expects treatment programs to conduct observed urine testing at least two times per week. The court generally only tests participants (1) upon admission, (2) when they move between phases, (3) if tests are missing from the program, and (4) upon completion.

2. [Pill and strip counting](#)

Who counts and how? Most participants receive methadone taken under supervision so there is no need to count strips or pills. For participants receiving buprenorphine, the court expects the treatment programs to determine if or when counting is necessary. Naltrexone is injected by a physician; therefore, there is no pill or strip counting.

3. [Observation](#)

The court expects programs to observe their participants for more subjective measures, such as how they are functioning generally. There may be indications, other than drug tests, that a participant needs more intervention.

4. [Communication with treatment providers](#)

Court staff emphasizes the importance of good communication with programs. Regular contact ensures that the court and program can address issues early on.

Regular contact also helps with monitoring medication use (and misuse) and progress in treatment generally. Highlights of the court's communication with treatment providers include:

5. [Use of multiple forms of communication](#)

Programs and the drug court team communicate through email and phone calls, in addition to formal written reports.

6. [Communication early and often with a problem-solving approach.](#)

The court wants to hear about problems when they arise so they can address them promptly.

7. [Communication of subjective observations](#)

Subjective observations include unexplained changes in behavior, and not just objective data like test results and attendance. The court thinks substance misuse usually becomes apparent through observation and the participant's general functioning.

If there is a lapse in communication with a program (e.g., not returning calls in a timely manner or not providing information upfront), the court contacts a manager. In the rare event that communication is still difficult, the court evaluates whether to continue referring participants to that program.

How does the court respond to non-compliance and relapse?

The court's range of responses to non-compliance is generally the same for all clients—MAT recipients and others. Interventions may include steps like a contract between the program and the client, or a reassessment of treatment needs, potentially leading to a higher level of care. The court might require the participant to write a letter to the judge, extend the length of the court mandate, or in extreme cases, impose a jail sanction.

In assessing the appropriate intervention if someone relapses while using MAT, the court considers if the person may not have yet reached the correct level of medication to achieve a blocking dose. The relapse might indicate a

need to increase medication, rather than to discontinue it. The court seeks input from the medical practitioner. As a staff member says, “it would be unethical to withhold medication as a sanction.” Clinical indications form the basis for medication decisions.

What are the sanctions for illicit use or sale of MAT medications?

Participants arrested for selling medication generally receive a jail sanction, just as they do for the illegal sale of any substance. This is rare, however, and the project director cannot even remember specific examples.

How pervasive is illicit diversion of MAT medication?

Staff thinks diversion is relatively uncommon among participants. They reduce its occurrence through monitoring and communicating that diversion results in clear consequences. As one team member says, “[Participants] really don’t want to come into court having messed up. Our judge can be tough.” They also believe that effective treatment decreases the risk of diversion. Since most participants go to methadone clinics, where staff observes participants taking their daily dose, the risk of diversion is minimal. Even the assigned prosecutor who prefers abstinence-based treatments thinks that there is effective monitoring of MAT and does not have concerns about court outcomes for participants who receive MAT.

Does allowing MAT create a burden and cost for the court?

Incorporating MAT has been relatively seamless for this court. In fact, it seems almost like a non-issue. The judge and assigned prosecutor pointed out that they rarely even note whether a particular participant is receiving MAT. They look at how the participant is doing in treatment and other aspects of their lives. Whether the participant receives MAT does not typically affect that assessment.

In terms of logistics, MAT is available from many of the programs with which the court already had relationships prior to its incorporation of MAT. The fact that the programs take responsibility for closely monitoring participants and

other associated tasks relieves the burden on the court. Moreover, clinical staff members generally feel that MAT significantly improves treatment outcomes, thereby reducing the overall burden on the court.

Who pays for MAT?

Almost all participants receive Medicaid coverage for MAT. Some participants work, but the court has not heard of difficulties paying for MAT once employed. Almost all participants receive methadone, which is generally the least expensive form of MAT treatment.

How did this court's MAT program begin?

Prior to 2005, the court saw few opioid addicted individuals and required most of them to taper off MAT before graduation. Key players, particularly the deputy district attorney who oversaw drug court, opposed MAT.

In 2005, the court began a misdemeanor program that permitted MAT and found it to be effective. Additionally, the felony court permitted some participants to receive MAT in response to letters from doctors with compelling accounts of participants' medical or psychiatric need for MAT. Those participants tended to be successful. As the drug court evolved, some staff who initially opposed MAT became more open to its use; others may not have changed their views, but deferred to clinicians. In 2009, when Rockefeller Drug Law reforms resulted in the creation of new Judicial Diversion courts and gave more discretion to judges, the court began permitting all opioid addicted individuals to receive MAT when clinically indicated.

IV. Specific Issues for Rural Drug Courts

Specific Issues for Rural Drug Courts

Drug courts serving rural areas can face unique challenges when implementing medication-assisted treatment programs. Yet, many rural courts have found ways to address hurdles and operate successful programs. Three of the 10 courts interviewed for this report serve exclusively rural areas; another five are in cities or suburbs with jurisdiction over rural areas. What follows are some of the challenges and solutions learned from these courts.

Scarcity of nearby treatment and limited transportation

All of the courts noted that in rural areas, treatment is limited, distances to programs greater, and public transportation minimal. Methadone maintenance treatment is generally the scarcest of MAT modalities, with opioid treatment programs far away and/or at capacity. The nearest methadone program to one rural court, for example, is an hour's drive, with long waiting lists.

Because of the limited availability of methadone, most of these courts rely on buprenorphine—generally from the same outpatient treatment programs attended by other participants. In two courts, a small number of participants receive buprenorphine from private doctors, even though the courts prefer to use licensed treatment programs. Because of concerns about the practices of some private doctors, one program requires participants to receive their MAT from a licensed treatment program until they complete the program, at which time they may receive it from a private doctor. Another court does not permit the use of private doctors who accept cash only.

These rural courts expect to incorporate injectable naltrexone as it becomes increasingly available. Travel distances make injectable naltrexone and buprenorphine more practical than methadone because they require fewer appointments. Courts also note that where participants rely on medi-cab reimbursements for travel, an essential strategy is to have them receive medication at their treatment program so they do not have to attend appointments at different locations.

Because treatment providers and court staff can have closer relationships in small towns, some rural courts have tried to expand treatment capacity by urging programs to offer MAT medication.

Smaller court staff

Rural courts typically have small staffs—just one person in addition to the judge—which can make monitoring more burdensome. To help stretch resources, some of these courts rely on the treatment programs and probation officers (where applicable) to conduct the lion’s share of the monitoring. For example, one rural court conducts random urine screens and monitors participants through behavioral observation, but only the treatment programs and probation conduct strip counting for buprenorphine. One court coordinator also notes that because they operate in a small community, they have especially close communication with the treatment providers. “We’re a tight team,” she says, and feels “very lucky” to be in a small town where the court can develop close relationships with the treatment programs.

In sum, rural courts may face different challenges to incorporating MAT. But as in other areas, there are viable strategies to make MAT available to treatment court participants.

Conclusion

Conclusion

Scientific evidence overwhelmingly shows that MAT is a critical tool in the treatment of opioid addiction and essential in fighting the opioid epidemic. Drug treatment courts can play a key role in ensuring that participants have access to this effective, evidence-based treatment, while also reducing crime. In fact, the law in New York now requires it.³¹

As shown in this report, incorporating MAT into a court's operations is not onerous but works best when done with planning and coordination. While use of MAT can pose challenges, especially when key players are not all on board, an array of strategies are available to address these challenges. Whether a court is rural, suburban or urban, or in any region of the state, it can use this report's concrete suggestions to begin or improve a MAT program. While MAT is not appropriate for every participant with opioid addiction, decisions about its use require individualized evaluations based on objective medical evidence. As such, MAT should be a key component in every court's tool-kit for treating opioid addiction.

Endnotes

1. *Memorandum in support of bill S4239B*, available at <http://www.nysenate.gov/legislation/bills/2015/S4239B>.
2. NY Crim. Proc. Law §§ 216.05(5) and (9)(a).
3. *Id.* 1.
4. LEGAL ACTION CENTER, LEGALITY OF DENYING ACCESS TO MEDICATION ASSISTED TREATMENT IN THE CRIMINAL JUSTICE SYSTEM (Dec. 1, 2011), http://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.
5. Harlon Matusow, et al., *Medication assisted treatment in US drug courts: Results from a nationwide survey of availability, barriers and attitudes*, J. SUBSTANCE ABUSE TREATMENT (2012), 4, available at <http://dx.doi.org/10.1016/j.jsat2012.10.004>.
6. Though the term “MAT” can also encompass treatment for a range of substance addictions, this report focuses only on the use of medication to treat opioid addiction.
7. Methadone is also prescribed for pain. This report, however, refers only to methadone maintenance treatment for opioid addiction.
8. MADY CHALK ET AL., TREATMENT RESEARCH INSTITUTE, FDA APPROVED MEDICATIONS FOR THE TREATMENT OF OPIATE DEPENDENCE: LITERATURE REVIEWS ON EFFECTIVENESS AND COST-EFFECTIVENESS (Jun. 2013) at 8, 11, 24-25, available at http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final; NATIONAL INSTITUTES OF HEALTH, NIH CONSENSUS STATEMENT: EFFECTIVE MEDICAL TREATMENT OF OPIATE ADDICTION (1997), at 15-17, available at <http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf>; OFFICE OF NATIONAL DRUG CONTROL POLICY, TREATMENT PROTOCOL EFFECTIVENESS STUDY (Mar. 1996), at 4, available at <https://www.ncjrs.gov/ondcppubs/publications/treat/trmtprot.html>; NATIONAL INSTITUTE OF DRUG ABUSE (NIDA), TOPICS IN BRIEF, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Apr. 2012), available at http://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf; National Institutes of Health, NIH Consensus Statement: Effective Medical Treatment of Opiate Addiction (1997), at 15-17, available at <http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf>; Jeannia F. Ju et al., *Forced withdrawal from methadone maintenance therapy in criminal justice settings: A critical treatment barrier in the United States*, J. SUBSTANCE ABUSE TREATMENT (2013), (citing Hedrich et al.; Kinlock et al., 2009; Larney et al., 1998; Sees et al., 2000; Sullivan et al., 2005; Zaller et al., 2010); John Kakko, MD et al., *1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomized, placebo-controlled trial*, 361 No.9358 LANCET, 662-668 (Feb. 22, 2013), available at <http://www.ncbi.nlm.nih.gov/pubmed/12606177>.
9. NIDA INTERNATIONAL PROGRAM, METHADONE RESEARCH WEB GUIDE, PART B: 20 QUESTIONS AND ANSWERS REGARDING METHADONE MAINTENANCE TREATMENT RESEARCH, PART B, B-1 (2013), <https://www.drugabuse.gov/sites/default/files/pdf/partb.pdf>.
10. Nora D. Volkow et al., *Medication-Assisted Therapies – Tackling the Opioid-Overdose Epidemic*, N. ENGL. J. OF MED., May 29, 2014, 2014, at 2064, available at <http://www.nejm.org/doi/full/10.1056/NEJMp1402780>, (citing Robert P. Schwartz et al., *Opioid Agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995-2009*, 103 No. 5 AM. J. PUB. HEALTH (2013) available at <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2012.301049>).
11. John Kakko, MD et al., *1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomized, placebo-controlled*

- trial*, 361 No.9358 LANCET, 662-668 (Feb. 22, 2013), available at <http://www.ncbi.nlm.nih.gov/pubmed/12606177>.
12. Ingrid A. Binswanger, MD et al., *After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009*, 159 No. 9 ANN. INTERN. MED. (Nov. 5, 2013) available at <http://annals.org/article.aspx?articleid=1763230>.
 13. NATIONAL INSTITUTE OF DRUG ABUSE (NIDA), TOPICS IN BRIEF, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Apr. 2012), available at http://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.
 14. Timothy W. Kinlock et al., *A Study of Methadone Maintenance for Male Prisoners: 3-Month Post Release Outcomes*, CRIM. JUST. BEHAV. (Jul. 8 2008), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2443939/>.
 15. *Id.*
 16. Joshua D. Lee et al., *Opioid treatment at release from jail using extended-release naltrexone*, ADDICTION (2015), available at <http://onlinelibrary.wiley.com/doi/10.1111/add.12894/epdf>.
 17. NATIONAL INSTITUTE OF DRUG ABUSE (NIDA), TOPICS IN BRIEF, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Apr. 2012), available at http://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.
 18. *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SVCS., NAT'L INST. OF HEALTH, NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT, NIH PUB. No. 12-4180, 26-27 (3rd Ed., Dec. 2012), available at http://www.drugabuse.gov/sites/default/files/podat_1.pdf.
 19. National Institute on Drug Abuse, *supra* note 8, at 2.
 20. American Society of Addiction Medicine, *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, (May 2015), available at <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/national-practice-guideline.pdf>.
 21. CENTER FOR DISEASE CONTROL, METHADONE MAINTENANCE TREATMENT, IDU/HIV PREVENTION (Feb. 2002), available at [http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20\(20\).pdf](http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20(20).pdf).
 22. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA), FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS, (Mar. 2015), 25 available at <http://store.samhsa.gov/shin/content/PEP-15FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf>.
 23. OFFICE OF NATIONAL DRUG CONTROL POLICY, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Sept. 2012), 3, available at http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.
 24. U.S. DEPT. OF HEALTH & HUMAN SVCS., SUBSTANCE ABUSE & MENTAL HEALTH ADMIN., MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS, TREATMENT IMPROVEMENT PROTOCOL (TIP) 43 (2005), available at <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>. *See also* David Mee-Lee, ed., *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, (Oct. 14, 2013), e-page 293, (noting that “the notion that the duration of treatment varies ... is a foundational principle of the ASAM criteria.”)
 25. NATIONAL INSTITUTE OF DRUG ABUSE (NIDA), TOPICS IN BRIEF, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Apr. 2012), available at http://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.

- www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.
26. U.S. DEP'T OF HEALTH & HUMAN SVCS, CENTERS FOR DISEASE CONTROL, METHADONE MAINTENANCE TREATMENT (Feb. 2002), *available at* [http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20\(20\).pdf](http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20(20).pdf), (citing NIDA, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH BASED GUIDE (1999), *available at* http://www.drugabuse.gov/sites/default/files/podat_1.pdf).
 27. Nora D. Volkow, Statement to the Senate Caucus on International Narcotics Control, *America's Addiction to Opioids: Heroin and Prescription Drug Abuse*, May 14, 2014, *available at* <https://www.hsdl.org/?view&did=754557>.
 28. OFFICE OF NATIONAL DRUG CONTROL POLICY, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Sept. 2012), *available at* http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf (citing Ed Day & John Strang, (2010)); *Outpatient versus inpatient opioid detoxification: a randomized controlled trial* [Electronic Version], 40J40J. OF SUBSTANCE ABUSE TREATMENT (Nov. 1, 2010), 46-66).
 29. OFFICE OF NATIONAL DRUG CONTROL POLICY, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Sept. 2012), *available at* http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.
 30. Information about the LOCADTR 3 tool is available through the New York State Office of Alcoholism and Substance Abuse Services, at <https://oasas.ny.gov/treatment/health/locadtr/index.cfm>.
 31. NY Crim. Proc. Law §§ 216.05(5) and (9)(a).

Appendices

Appendix A

FDA-Approved Medications for Substance Use Disorders			
Name	Naltrexone (Vivitrol®)	Buprenorphine	Methadone
Molecular Structure	Antagonist	Agonist	Agonist
Treatment Use	Opioid dependence	Opioid dependence	Opioid dependence
Controlled Substance?	Schedule 0	Schedule III	Schedule II
Abuse Potential	No	Yes	Yes
Trade Name	Vivitrol	Suboxone®* *includes naloxone	Methadone
How administered	Intramuscular injection	Oral tablet or sublingual film taken once daily	Oral Solution
How the medication works	By blocking opioid receptors, it blocks cue-triggered craving	A long-acting partial opioid, it relieves withdrawal, decreases craving, and prevents euphoria if other opioids are used	A long-acting “full” opioid that relieves withdrawal, blocks craving, and prevents euphoria if other opioids are used
Special licensing or credential required?	No	Varies by state	Yes
Year approved by FDA for Addiction Treatment	2006	2002	1947 – Approved dispersible tablet for treatment of addiction
Physician training required?	No	Yes – 8 hours of training required	No
Typical Duration	Up to 30 days	1 day	1 day
Detoxification or Stabilization	Detoxification & 7-10 days of complete abstinence from opioids	Detoxification	Can be used for detoxification and/or stabilization

OFFICE OF NATIONAL DRUG CONTROL POLICY, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Sept. 2012), 5, available at https://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

Appendix B



RESOLUTION OF THE BOARD OF DIRECTORS

ON THE AVAILABILITY OF MEDICALLY ASSISTED TREATMENT (M.A.T.) FOR ADDICTION IN DRUG COURTS

WHEREAS, addiction to illicit drugs and alcohol is, in part, a neurological or neuro-chemical disorder characterized by chronic physiological changes to brain regions governing motivation, learning, attention, judgment, insight, and affect regulation¹⁻⁵; *and*

WHEREAS, certain medically assisted treatments (M.A.T.) for addiction – including antagonist medications such as naltrexone, agonist medications such as methadone, and partial agonist medications such as buprenorphine – have been proven through rigorous scientific studies to improve addicted offenders' retention in counseling and reduce illicit substance use, re-arrests, technical violations, re-incarcerations, hepatitis C infections, and mortality⁶⁻¹²; *and*

WHEREAS, the availability and use of M.A.T. for addiction is endorsed by leading scientific and practitioner organizations in the substance abuse treatment field¹³⁻¹⁷; *and*

WHEREAS, despite the proven efficacy of M.A.T., it is infrequently available for addicted individuals involved in the criminal justice system¹⁸⁻²⁰; *and*

WHEREAS, the conditions for participation in Drug Court, like those of probation, should be based on a particularized determination in each case that the conditions are reasonably related to the goals of protecting public safety, rehabilitating the offender, or ensuring the offender's appearance in court²¹:

NOW, THEREFORE, BE IT RESOLVED THAT:

- 1. Drug Court professionals have an affirmative obligation to learn about current research findings related to the safety and efficacy of M.A.T. for addiction.**
- 2. Drug Court programs should make reasonable efforts to attain reliable expert consultation on the appropriate use of M.A.T. for their participants. This includes partnering with substance abuse treatment programs that offer regular access to medical or psychiatric services.**
- 3. Drug Courts do not impose blanket prohibitions against the use of M.A.T. for their participants. The decision whether or not to allow the use of M.A.T. is based on a particularized assessment in each case of the needs of the participant and the interests of the public and the administration of justice.**
- 4. Drug Court judges base their decision whether or not to permit the use of M.A.T., in part, on competent expert evidence or consultation. In cases in which a participant, the participant's legal counsel, or a medical expert has requested the possible use of M.A.T., the judge articulates the rationale for allowing or disallowing the use of addiction medication.**
- 5. Nothing in this Resolution prevents a Drug Court from imposing consequences on a participant for failing to respond to drug-free counseling, if M.A.T. was made available to the participant but was refused.**

¹ Baler, R. D., & Volkow, N. D. (2006). Drug addiction: The neurobiology of disrupted self-control. *Trends in Molecular Medicine*, 12, 559-566.

² Chandler, R. K., Fletcher, B. W., & Volkow, N. D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association*, 301, 183-190.

³ Dackis, C., & O'Brien, C. (2005). Neurobiology of addiction: Treatment and public policy ramifications. *Nature Neuroscience*, 8, 1431-1436.

⁴ Goldstein, R. Z., Craig, A. D., Bechara, A., Garavan, H., Childress, A. R., Paulus, M. P., & Volkow, N. D. (2009). The neurocircuitry of impaired insight in drug addiction. *Cell*, 13, 372-380.

⁵ McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA*, 284, 1689-1695.

⁶ Cornish, J. W., Metzger, D., Woody, G. E., Wilson, D., McLellan, A. T., Vandergrift, B. (1997). Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment*, 14, 529-534.

- ⁷ Dolan, K. A., Shearer, J., White, B., Zhou, J., Kaldor, J., & Wodak, A. D. (2005). Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, re-incarceration and hepatitis C infection. *Addiction, 100*, 820-828.
- ⁸ Gordon, M. S., Kinlock, T. W., Schwartz, R. P., & O'Grady, K. E. (2008). A randomized clinical trial of methadone maintenance for prisoners: Findings at 6 months post-release. *Addiction, 103*, 1333-1342.
- ⁹ Kinlock, T. W., Gordon, M. S., Schwartz, R. P., & O'Grady, K. E. (2008). A study of methadone maintenance for male prisoners: Three-month postrelease outcomes. *Criminal Justice & Behavior, 35*, 34-47.
- ¹⁰ Magura, S., Lee, J. D., Hershberger, J., Joseph, H., Marsch, L., Shropshire, C., & Rosenblum, A. (2009). Buprenorphine and methadone maintenance in jail and post-release: A randomized clinical trial. *Drug & Alcohol Dependence, 99*, 222-230.
- ¹¹ O'Brien, C. P., & Cornish, J. W. (2006). Naltrexone for probationers and prisoners. *Journal of Substance Abuse Treatment, 31*, 107-111.
- ¹² Stallwitz, A., & Stover, H. (2006). The impact of substitution treatment in prisons—A literature review. *International Journal of Drug Policy, 18*, 464-474.
- ¹³ National Institute on Drug Abuse. (2006). *Principles of drug abuse treatment for criminal justice populations* [NIH Pub. No. 06-5316]. Bethesda, MD: Author.
- ¹⁴ Center for Substance Abuse Treatment. (2004). *Clinician guidelines for the use of buprenorphine in the treatment of opioid addiction* [Treatment Improvement Protocol (TIP) Series 40, DHHS Publication No. (SMA) 04-3939]. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- ¹⁵ Center for Substance Abuse Treatment. (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs* [Treatment Improvement Protocol (TIP) Series 43, DHHS Publication No. (SMA) 05-4048]. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- ¹⁶ Center for Substance Abuse Treatment (2009). *Incorporating alcohol pharmacotherapies into medical practice*. [Treatment Improvement Protocol (TIP) Series 49. HHS Publication No. (SMA) 09-4380]. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- ¹⁷ National Drug Court Institute. (2002). *Methadone maintenance and other pharmacotherapeutic interventions in the treatment of opioid dependence* [Practitioner Fact Sheet Vol. III, No. I]. Alexandria, VA: Author.
- ¹⁸ Taxman, F. S., Perdoni, M. L., & Harrison, L. D. (2007). Drug treatment services for adult offenders: The state of the state. *Journal of Substance Abuse Treatment, 32*, 239-254.
- ¹⁹ Nunn, A., Zaller, N., Dickman, S., Trimbur, C., Nijhawan, A., & Rich, J. D. (2009). Methadone and buprenorphine prescribing and referral practices in US prison systems: Results from a nationwide survey. *Drug & Alcohol Dependence, 105*, 83-88.
- ²⁰ Chandler, et al. (2009), *supra* note 2.
- ²¹ See, e.g., *Roberts v. United States*, 320 U.S. 264, 272, 88 L. Ed. 41, 64 S. Ct. 113 (1943) (holding basic purpose of probation is to provide individualized program of rehabilitation); *Commonwealth v. Wilson*, 2010 PA Super 233, 11 A.3d 519 (2010) (finding primary concern of probation is rehabilitation, and probation order must be unique and individualized); *In re. Victor L.*, 182 Cal.App.4th 902, 106 Cal.Rptr.3d 584 (2010) (requiring individualized approach to probation conditions); *State v. Philipps*, 242 Neb. 894, 496 N.W.2d 874 (1993) (finding it necessary to give careful, humane and comprehensive consideration to particular situation of each probationer); *Commonwealth v. Hartman*, 908 A.2d 316, 320 (Pa. Super. 2006) (stating conditions of probation must be reasonable); *People v. Beaty*, 181 Cal.App.4th 644, 105 Cal.Rptr.3d 76 (2010) (holding restrictions on medical marijuana by probationers must be reasonably related to offense and based on medical evidence); *People v. Carbajal*, 10 Cal.4th 1114, 43 Cal.Rptr.2d 681, 899 P.2d 67 (1995) (concluding probation conditions must be reasonably related to the crime or risk of future criminality).

Appendix C



Medication-Assisted Treatment for Opioid Addiction *Myths and Facts*

Medication-assisted treatment (MAT) for opioid addiction is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to treatment. MAT utilizes medications, such as methadone, buprenorphine, and injectable naltrexone, to stabilize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions. Numerous studies have shown that MAT reduces illicit drug use, disease rates, and criminal activity among opioid addicted persons.¹ Despite overwhelming evidence of MAT's benefits, many people view it negatively. As a result, they do not use MAT and sometimes prohibit it even when clinically appropriate. Following are common myths and facts about MAT. Relying on the facts will increase the chance that people will enter and sustain recovery.

Myth: *MAT “substitutes one addiction for another.”*

Fact: Though two of the three MAT medications are opioid-based, they are fundamentally different from short-acting opioids such as heroin and prescription painkillers. The latter go right to the brain and narcotize the individual, causing sedation and the euphoria known as a “high.” In contrast, addiction medications like methadone and buprenorphine, when properly prescribed, reduce drug cravings and prevent relapse without causing a “high.”² They help patients disengage from drug seeking and related criminal behavior and become more receptive to behavioral treatments.³ Injectable naltrexone is not opioid based and does not result in physical dependence.⁴

Myth: *Addiction medications are a “crutch” that prevents “true recovery.”*

Fact: Leading addiction professionals and researchers have concluded that individuals stabilized on MAT can achieve “true recovery.” This is because such individuals do not use illicit drugs; do not experience euphoria, sedation, or other functional impairments; and do not meet diagnostic criteria for addiction, such as loss of volitional control over drug use.⁵ MAT consists not only of medication but also of behavioral interventions like counseling. The medication normalizes brain chemistry so individuals can focus on counseling and participate in behavioral interventions necessary to enter and sustain recovery.⁶

Myth: *MAT should not be long term.*

Fact: There is no one-size-fits-all duration for MAT. The Substance Abuse and Mental Health Services Administration (“SAMHSA”) recommends a “phased approach,” beginning with stabilization (withdrawal management, assessment, medication induction, and psychosocial counseling), and moving to a middle phase that emphasizes medication maintenance and deeper work in counseling. The third phase is “ongoing rehabilitation,” when the patient and provider can choose to taper off medication or pursue longer term maintenance, depending on the patient’s needs.⁷ For some patients, MAT could be

indefinite.³ The National Institute on Drug Abuse (“NIDA”) describes addiction medications as an “essential component of an *ongoing* treatment plan” to enable individuals to “take control of their health and their lives.”⁹ For methadone maintenance, NIDA states that “12 months of treatment is the minimum.”¹⁰

Myth: *Requiring people to taper off MAT helps them get healthy faster.*

Fact: Requiring people to stop taking their addiction medications is counter-productive and increases the risk of relapse.¹¹ Because tolerance to opioids fades rapidly, one episode of opioid misuse after detoxification can result in life-threatening or deadly overdose.¹²

Myth: *Courts are in a better position than doctors to decide appropriate drug treatment.*

Fact: Deciding the appropriate treatment for a person with opioid addiction is a matter of physician discretion, taking into consideration the relevant medical standards and the characteristics of the individual patient.¹³ Just as judges would not decide that a person should treat her diabetes through exercise and diet alone, and instruct her to stop taking insulin, courts are also not trained to make medical decisions with respect to medically-accepted addiction treatment.

³ Mady Chalk et al., Treatment Research Institute, FDA Approved Medications for the Treatment of Opiate Dependence: Literature Reviews on Effectiveness and Cost-Effectiveness (Jan. 2013) at 8, 11, 24-25, available at http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final; National Institutes of Health, NIH Consensus Statement: Effective Medical Treatment of Opiate Addiction (1997), at 15-17, available at <http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf>; National Institute of Drug Abuse (NIDA), Topics in Brief, Medication-Assisted Treatment for Opioid Addiction (Apr. 2012), available at http://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.

² NIDA, *supra* note 1, at 1.

³ See, e.g., NIDA, Principles of Drug Addiction Treatment 11 (Martin W. Adler, Ph.D. et al., eds. 3d ed., 2012), available at http://www.drugabuse.gov/sites/default/files/podat_1.pdf.

⁴ NIDA, *supra* note 1, at 2.

⁵ See, e.g., William L. White & Lisa Mauer-Torres, Recovery-Oriented Methadone Maintenance 5 (2010); The American Society of Addiction Medicine, The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions 5 (David Mee-Lee ed., 2013), available at http://www.williamwhitepapers.com/pr/_books/full_texts/2010Recovery_orientedMethadoneMaintenance.pdf.

⁶ NIDA, Drug Facts: Treatment Approaches for Drug Addiction (2009), available at <http://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>.

⁷ Office of National Drug Control Policy, Medication-Assisted Treatment for Opioid Addiction 3 (2012), available at http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

⁸ Substance Abuse and Mental Health Services Administration, Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: A Treatment Improvement Protocol TIP 43 (2008), available at <http://store.samhsa.gov/shin/content/SMA124108/SMA124108.pdf>.

⁹ NIDA, *supra* note 1, at 1.

¹⁰ NIDA, Understanding Drug Abuse and Addiction, (2007) available at <http://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/6-duration-treatment>.

¹¹ Office of National Drug Control Policy, *supra* note 5, at 3 (citing E. Day & J. Strang, *Outpatient Versus Inpatient Opioid Detoxification: A Randomized Controlled Trial*, 40 J. of Substance Abuse Treatment, 1, 56-66 (2010)).

¹² Office of National Drug Control Policy, *supra* note 5, at 3.

¹³ See, e.g., The American Society of Addiction Medicine, The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (David Mee-Lee, ed., 2013).

Appendix D

Topics in Brief

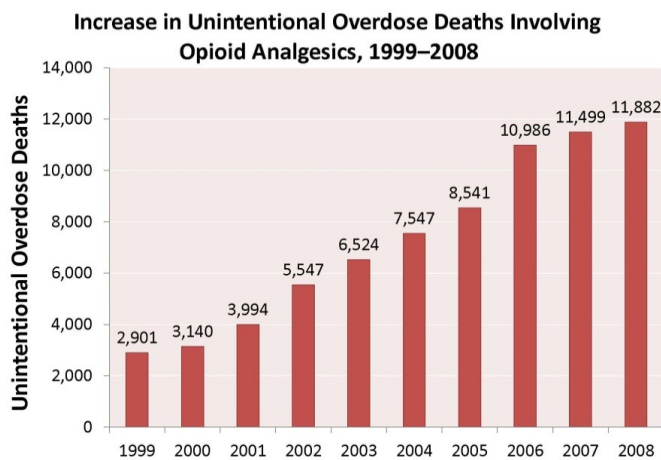
National Institute on Drug Abuse



Medication-Assisted Treatment for Opioid Addiction – April 2012

Addiction to opioids (e.g., heroin, morphine, prescription pain relievers) is a serious global problem that affects the health, social, and economic welfare of all societies. An estimated 12–21 million people worldwide abuse opioids, with 1.9 million people in the U.S. addicted to prescription opioid pain relievers in 2010 and 359,000 addicted to heroin. Consequences of this abuse have been devastating and are on the rise. For example, the number of unintentional overdose deaths from prescription pain relievers has soared in the U.S., quadrupling since 1999.

Opioids act on specific receptors in the brain and the body, which also interact with naturally produced substances known as endorphins or enkephalins – important in regulating pain. While prescription pain relievers can be highly beneficial if used as prescribed, opioids as a general class of drugs have a high potential for abuse.



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, accessed through CDC WONDER Online Database, released 2011.

Abuse of opioids, especially heroin, is also linked with the transmission of human immunodeficiency virus (HIV), hepatitis, sexually transmitted infections (STIs), and other blood-borne diseases mostly through the use of unsterile drug paraphernalia, but also through the risky behavior that drug abuse may engender. Thus, treatment of drug abuse not only frees individuals from the vicious cycle of addiction, but can also prevent related adverse health consequences.

Medications – A Critical Component of Opioid Addiction Treatment

Drug abuse changes the way the brain works, resulting in compulsive behavior focused on drug seeking and use, despite sometimes devastating

consequences—the essence of addiction. Therefore, drug abuse treatment must address these brain changes, both in the short and long term. When people addicted to opioids first quit, they undergo withdrawal symptoms, which may be severe (pain, diarrhea, nausea and vomiting). Medications can be helpful in this detoxification stage to ease craving and other physical symptoms, which often prompt relapse. However, this is just the first step in treatment. Medications may also become an essential component of an *ongoing* treatment plan, enabling opioid-addicted persons to regain control of their health and their lives.

Medications developed to treat opioid addiction work through the same receptors as the addictive drug, but are safer and less likely to produce the harmful behaviors that characterize addiction. Three types include (1) agonists, which activate opioid receptors; (2) partial agonists, which also activate opioid receptors but produce a diminished response; and (3) antagonists, which block the receptor, and interfere with the rewarding effects of opioids. Physicians prescribe a particular medication based on a patient's specific medical needs and other factors. Effective medications include:

- **Methadone** (Dolophine or Methadose), a slow-acting, opioid agonist. Methadone is taken orally, so that it reaches the brain slowly, dampening the “high” that occurs with other routes of administration while preventing withdrawal symptoms. Methadone has been in use since the 1960s to treat heroin addiction and is still an excellent treatment option, particularly for patients that do not respond well to other medications; however, it is only available through approved outpatient treatment programs, where it is dispensed to patients on a daily basis.
- **Buprenorphine** (Subutex, Suboxone), a partial opioid agonist. Buprenorphine relieves drug cravings without producing the “high” or dangerous side effects of other opioids. **Suboxone** is a novel formulation, taken orally, that combines buprenorphine with naloxone (an opioid antagonist) to ward off attempts to get high by injecting the medication. If an addicted patient were to inject Suboxone, the naloxone would induce withdrawal symptoms,

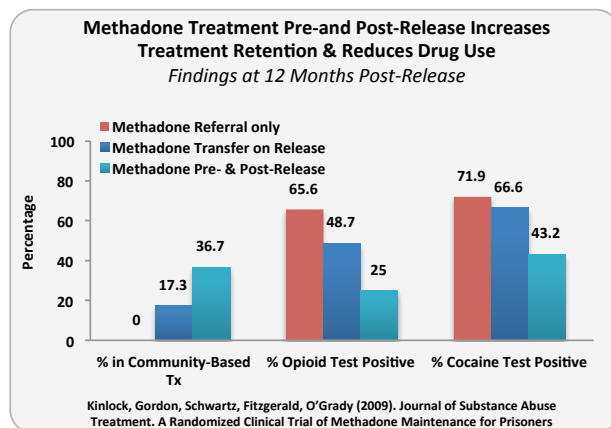
which are averted when taken orally as prescribed. The FDA approved buprenorphine in 2002, making it the first medication eligible to be prescribed by certified physicians through the Drug Addiction Treatment Act. This approval eliminates the need to visit specialized treatment clinics, expanding treatment access.

- **Naltrexone** (Depade, Revia) an opioid antagonist. Naltrexone is not addictive or sedating and does not result in physical dependence; however, poor patient compliance has limited its effectiveness. Recently an injectable long acting formulation of naltrexone called **Vivitrol** received FDA approval for treating opioid addiction. Given as a monthly injection, Vivitrol should improve compliance by eliminating the need for daily dosing. To avoid withdrawal symptoms, Vivitrol should be used only after a patient has undergone detoxification. Vivitrol provides an effective alternative for individuals who are unable to or choose not to engage in agonist-assisted treatment.

Benefits of Medication-Assisted Treatment – Beyond Reducing Drug Use

Scientific research has established that medication-assisted treatment of opioid addiction increases patient retention and decreases drug use, infectious disease transmission, and criminal activity. For example, studies among criminal offenders, many of whom enter the prison system with drug abuse problems, showed that methadone treatment begun in prison and continued in the community upon release extended the time parolees remained in treatment, reduced further drug use, and produced a three-fold reduction in criminal activity.

Investment in medication-assisted treatment of opioid addiction also makes good economic sense. For methadone, every dollar invested in treatment generates an estimated \$4–5 return.



Research Reveals New Strategies for Addiction Medications

NIDA is committed to supporting research to improve opioid addiction treatment, including behavioral therapies, which can be an important component of long-term recovery. Equally important is ensuring that these improvements reach all affected communities.

Improved medications – Probuphine is a long-acting version of buprenorphine that is showing promise in clinical trials. An implant inserted under the skin, Probuphine can deliver medication continuously for 6 months. Like Vivitrol, it aims to prevent abuse and diversion and increase treatment adherence by eliminating the need for daily dosing.

Vaccine research – Vaccines are being developed to help combat a variety of addictions including heroin. A **heroin vaccine**, currently under development, would corral heroin in the bloodstream and prevent it from reaching the brain and exerting its euphoric effects. This approach could guard against relapse and be an effective addition to a comprehensive treatment plan for heroin addiction.

Reaching Into the Community

NIDA is collaborating with SAMHSA and others to accelerate the translation of research discoveries into clinical practice, including the use of medication-assisted treatment. To learn more about these efforts, please visit: <http://www.drugabuse.gov/publications/nidasamhsa-blending-initiative>

For further information please visit NIDA on the web at www.drugabuse.gov or contact:

Public Information and Liaison Branch
Office of Science Policy and Communications
Phone 301-443-1124/Fax 301-443-7397
information@nida.nih.gov

Appendix E

Further Resources

Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence, (Summer 2014), by Substance Abuse and Mental Health Services Administration (SAMSHA), available at <http://store.samhsa.gov/shin/content//SMA14-4852/SMA14-4852.pdf>.

Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends, (Summer 2014), by Substance Abuse and Mental Health Services Administration (SAMSHA), available at <http://store.samhsa.gov/shin/content//SMA14-4443/SMA14-4443.pdf>.

Medication Assisted Therapies – Tackling the Opioid Overdose Epidemic, by Volkow, N., Frieden, T. et al., in *New England Journal of Medicine*, (May 29, 2014), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1402780>.

Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System, (December 1, 2011), by the Legal Action Center, available at http://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.

Notes

CENTER
FOR
COURT
INNOVATION

**Research. Development.
Justice. Reform.**

520 Eighth Avenue, New York, New York 10018
P 646 386 3100 F 212 397 0985 courtinnovation.org