

Incorporating Medication in Opioid Courts

Reducing Overdose Through Triage
in Treatment Court Settings



Opioid
Response
Network

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Abstract

To manage the opioid crisis in the United States, the justice system has adapted to develop approaches that address opioid use disorder (OUD) while reducing incarceration. One important effort is opioid intervention courts, specialized programs that draw on the experience of other evidence-based treatment courts to offer immediate connections to medication for opioid use disorder (MOUD) and intensive supervision and support. Opioid courts have succeeded in saving lives, but they also face barriers to enrolling participants and delivering MOUD to all who would benefit from it. This report is motivated by a desire to improve access to MOUD, specialty care, community support services, and peer advocates through opioid courts and other drug treatment courts. It shares lessons from opioid court practitioners and their partners about what quality MOUD care, treatment, and use look like; how to promptly identify potential court participants and provide access to MOUD and specialty care; and how to identify and engage MOUD providers. It also includes descriptions of recent innovations developed during the COVID-19 pandemic that could make it easier to connect patients to MOUD in the future. The goal is to assist practitioners in treatment courts and other settings as they seek to improve access to MOUD and specialty treatment services as part of the criminal legal process.

I. Introduction

The United States faces an urgent crisis of opioid use and overdose deaths. Heroin, prescription pain relievers, and synthetic opioids like fentanyl stand at the center of a deadly national epidemic that has surged during the COVID-19 crisis. More than 87,000 people died from drug overdoses in the year leading up to September 2020, and overdose deaths involving synthetic opioids rose 38.4 percent during that period.¹ Increasingly, fentanyl appears in other drugs, including stimulants like cocaine and methamphetamine, contributing to a dramatic increase in stimulant overdose in recent years. Fentanyl was detected in 80.4 percent of opioid overdose deaths involving stimulants between January and June of 2019.²

Underlying opioid use disorder (OUD) and the overdose crisis is the disease of addiction. “Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences,” according to the American Society of Addiction Medicine (ASAM). Influences from the environment and a person’s life experiences may include social determinants of health such as a history of trauma, housing and income instability, and a structural lack of access to care, which can contribute to and compound the underlying disease. “People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences,” ASAM continues. “Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.”³

The harmful consequences of OUD pose special challenges for the justice system. Opioid-related arrests have increased, and police, probation officers, corrections officers, and court staff are frequently called upon to respond to people suffering overdoses and severe withdrawal symptoms.⁴ To manage these challenges, they have worked to develop approaches that address OUD while reducing incarceration. One important effort is opioid intervention courts and other specialized programs designed to offer immediate connections to evidence-based treatment including medication for opioid use disorder (MOUD)

and intensive supervision and support.

MOUD has long been an effective approach to treating OUD. The medications methadone, buprenorphine, and long-acting, injectable naltrexone,⁵ in combination with counseling and behavioral therapies, help to stabilize the immediate withdrawal symptoms associated with opioid use cessation and begin a process of long-term recovery. Research shows that MOUD reduces drug use, disease rates, overdose deaths, and criminal activity while also increasing treatment engagement among patients with OUD.⁶ According to the National Institute of Drug Abuse, the longer patients remain in MOUD treatment the better their outcomes.⁷ More importantly, research has shown repeatedly that it is safer and more effective to use MOUD than not to use it. Studies demonstrate that the incidence of fatal overdose for people who do not receive MOUD is as high as 20 percent while it is 0 percent for those who continue MOUD treatment.⁸ For people with OUD, MOUD is now the recognized standard of care, and connecting them to MOUD treatment should be the first line of intervention.

Drug treatment courts are an evidence-based justice system intervention for connecting people to treatment for substance use disorder and reducing criminal recidivism.⁹ Drug courts have been effective in reducing drug use among people who, at baseline, used drugs more often and had a more serious primary drug of choice than marijuana, such as cocaine, heroin, or methamphetamine.¹⁰ However, people with OUD may be disqualified from participation in traditional drug courts because they do not meet the courts’ strict eligibility requirements; often, they face less serious charges, like simple possession, and present a low risk of recidivism.¹¹ Even when they are accepted into a drug court, the treatment they receive may not be immediate enough to address their overdose risk.¹² In the past, a variety of barriers—including a lack of understanding about the science of OUD and the effectiveness of MOUD, the belief that using MOUD is “substituting one drug for another,” and concerns that MOUD is not a practical fit within the drug court model—also prevented many drug courts from permitting patients to enroll in and be maintained on MOUD.¹³ Through a combination of state and federal guidance, research outcomes,

and practical use, drug courts came to recognize the need for an additional mechanism to enroll the broad population of people with low-level opioid offenses who were unlikely to take a plea, yet needed immediate access to MOUD and other treatment services for OUD.

In 2017, the Buffalo City Court designed an opioid court, an expansion of its many innovative treatment courts. It has become a national example by innovating ways to rapidly link participants with evidence-based treatment, and other drug courts have established opioid courts based on their recognition of this need. In most cases, opioid courts sit within drug courts and take advantage of existing staff, relationships, and resources to more effectively triage participants' immediate needs, serve the large population that may not take a plea, and create a pathway for longer-term care including MOUD. Preliminary findings from a recent study by NPC Research, funded by BJA, show that the opioid court at Buffalo City Court is succeeding in its primary goal of saving lives: participants are half as likely to die of a drug overdose within one year of enrollment when compared to people using opioids who were arrested and experienced typical case processing.¹⁴ New York has expanded the model to other regions of the state, establishing a total of 25 new opioid courts through its Unified Court System (UCS).

Opioid courts use a person's initial contact with police or the justice system as an opportunity to identify OUD and engage potential participants using non-traditional and non-coercive measures. This includes immediate screening, treatment engagement, intensive judicial monitoring, and recovery support to prevent opioid overdose and set participants on a path to long-term recovery. Opioid courts suspend the prosecution of cases while patients are in treatment and do not punish people who honestly admit to using again. Importantly, all opioid courts in New York State also offer access to MOUD prescription as part of their practices, in acknowledgment of the research demonstrating its efficacy both as an immediate life-saving measure and for maintenance. As one project director of a New York City opioid court said, "If there's a medication that will help participants to not use and to not die, who are we to prohibit it?"¹⁵

However, opioid courts face their own barriers

to enrolling participants and delivering MOUD to all who would benefit from it. New York State's recently implemented Criminal Justice Reform Act (CJRA),¹⁶ despite its many positive impacts, makes it more difficult to attract people to opioid court programs. Traditionally, treatment courts used the crisis of an arrest and the coercive power of the legal process to motivate people to accept treatment as an alternative to incarceration. But the CJRA removes that lever by eliminating bail for nonviolent felonies and mandating desk appearance tickets for most misdemeanors that are eligible for treatment court. This reduces the appeal of diversion programs because many people are less incentivized to enroll in a court-supervised treatment program without the benefit of avoiding jail. It also delays court contact with potential court participants, reducing opportunities for early intervention.

Other barriers prevent opioid courts from offering MOUD access. In many remote and rural jurisdictions, courts lack access locally to a federally-licensed opioid treatment program, the only locations at which methadone can be prescribed.¹⁷ Buprenorphine access is also subject to limitations. To prescribe the medication, practitioners must hold a buprenorphine waiver, and while many practitioners do, a significant proportion do not currently use it or prescribe to the capacity that it allows—often because they lack the training or staff to support patients with OUD.¹⁸ (In late April of 2021, during final preparations of this document, federal requirements for prescribing buprenorphine were broadened to include the ability for some types of prescribers to obtain a waiver from SAMHSA to treat up to 30 patients without having to meet certain certification requirements.¹⁹) Similarly, the long-acting, injectable forms of naltrexone and buprenorphine are complicated and time-consuming for prescribers to locate, obtain, and store, as well as being cost-prohibitive for many patients who are uninsured. Some opioid court participants face challenges to appearing at in-person appointments for MOUD prescriptions and maintenance. Even in locations where telehealth services are available for remote appointments, underserved patients may lack computers, smartphones, or WiFi and data coverage. Meanwhile, as mixing fentanyl into stimulants becomes more frequent, there is also

a possibility that people at high risk of overdose due to stimulant use may be excluded from opioid courts because courts perceive them to be low-risk and not to need triage. Finally, opioid courts also struggle with stigma from court, medical, and mutual support communities against OUD, MOUD prescription, and criminal justice involvement.

Beyond these issues, research has shown that race, ethnicity, and income play a significant role in access to certain forms of MOUD, in New York State and elsewhere. Non-Black and non-Latinx patients with higher incomes are more likely to receive buprenorphine treatment, while Black and Latinx patients with lower incomes are more likely to receive methadone treatment, a fact that can increase stigma toward low-income patients of color.²⁰ These factors have contributed to bifurcated models of care in which low-income patients of color often receive methadone treatment requiring daily clinic visits and close scrutiny, while middle-class White patients often receive more discrete, less intrusive buprenorphine treatment administered outside of clinics.²¹ Moreover, implicit racial bias among physicians is common in the medical profession, and Black patients who perceive their provider as discriminatory are more likely to cease treatment for substance use disorder.²² In general, Black patients are less likely to accept MOUD treatment due to mistrust of the American health care, social services, and criminal justice systems, which have historically contributed to their oppression.²³ These facts present a particular challenge, since Black Americans now face the highest rate of increase in opioid deaths.²⁴

Opioid courts have worked to address these barriers. They have responded to the lack of legal leverage by developing new incentives to encourage voluntary participation, such as allowing participants to defer the prosecution of a criminal case, enrolling them in the program on a pre-plea basis, using fewer sanctions for non-compliance, emphasizing positive reinforcement for attendance, and not requiring a commitment to long-term abstinence from all substances in order to participate. They have also supported participant engagement by providing more immediate access to MOUD, health, mental health, peer advocate, and recovery support services on a voluntary basis.

Many courts have expanded telehealth services to reach more patients. Finally, courts have benefited from an evolving concept of recovery that recognizes more pathways and includes a greater acceptance of MOUD. Yet much work still remains to be done.

The goal of this report is to identify ways for opioid courts and other drug treatment courts to improve access to MOUD. It shares lessons from opioid court practitioners and their partners about what quality MOUD care, treatment, and use look like; how to promptly identify potential court participants and provide access to MOUD and specialty care; and how to identify and engage MOUD providers. The goal is to assist an audience of practitioners in treatment courts and all criminal courts where people at risk of overdose have cases, as well as partners and potential partners of treatment courts (including treatment providers, health care practitioners, law enforcement officials, probation departments, and social service agencies), as they seek to improve access to MOUD and specialty treatment services as part of the criminal legal process.

While this report was in progress, the country began to experience the effects of COVID-19. The pandemic drove an increase in drug use and overdoses and disrupted court operations, treatment programs, and health services.²⁵ It also led to policy changes by the government—such as waiving requirements for in-person visits before beginning MOUD, relaxing prescribing regulations to allow clinicians to write prescriptions for longer periods, and increasing opportunities for telehealth counseling—that improved access to life-saving services. Accordingly, this report also includes perspectives from practitioners considering very recent innovations that could make it easier to connect patients to MOUD in the future.

II. Findings

To produce the findings in this report, the authors conducted in-depth interviews with 40 practitioners from across disciplines, including treatment providers; prescribers; office-based addiction treatment programs; opioid court case managers, coordinators, and project directors; harm reduction specialists; judges; researchers; justice-involved people; and people with lived experience of recovery. The authors asked these interviewees questions about their experience with partnerships between opioid courts and prescribers, settings for prescribing and induction, added responsibilities for prescribers, business models and reimbursement, ways to address stigma, roles for peer advocates, coordination of care, and telehealth services. Practitioners offered a range of perspectives, made recommendations, and offered resources based on their work under the current system New York State’s opioid courts use to connect participants with MOUD. The authors reviewed these practitioner perspectives and several important themes emerged in the findings, which are presented here in the form of distinct recommendations.

Provide immediate screening and treatment

Practitioners reported that it is extremely important that courts offer patients MOUD access as soon as possible, because they suffer potentially grave consequences if forced to wait for treatment while they move through the legal process. “From a clinical standpoint, as soon as you’ve got them, treat them,” said Linda Sacco, head of clinical services at Kaden Health, a company that provides MOUD prescriptions along with individual and group therapy through its online platform.²⁶ This approach offers patients the best chance of recovery and favorable criminal justice outcomes. Practitioners recommended the following.

- 1. Screen and treat patients on a pre-plea basis:** Providing patients with treatment on a pre-plea basis distinguishes opioid courts from many traditional drug courts. Court staff reported

that they typically screen patients before, during, or immediately after arraignment. They use validated risk assessment tools, and employ broad eligibility requirements for participation.²⁷ During screening, court staff determines patients’ eligibility for treatment court programs, allows them to opt into MOUD and treatment immediately, and connects them to an opioid treatment program or provider that prescribes the MOUD option they need.

At Syracuse Opioid Court, a community resource provider meets patients in jail to assess them as candidates for opioid court, begin the process of referral to services, and connect them with MOUD prescribers as soon as possible.²⁸ At the Bronx Overdose Avoidance and Recovery Court, staff conducts identification and assessment of candidates for opioid court and MOUD while defendants are awaiting arraignment or immediately thereafter. That jurisdiction has also worked with its police precinct to identify candidates immediately after arrest, a measure that assists patients who would otherwise face a delay in assessment while they awaited arraignment under the recent CJRA bail reform.²⁹ Researchers and clinicians said that it is a best practice for courts to offer patients a telehealth services link for MOUD assessment before connecting them with other psychosocial and community-based treatments.³⁰ (For more on telehealth services, see the recommendation “Provide telehealth access to treatment” on p. 13.)

- 2. Screen for co-occurring disorders:** Clinicians stressed that courts should screen patients not only for opioid and other substance use disorders but for co-occurring mental health disorders and social determinants of health. They should also learn about patients’ histories with psychiatric and other medications. Devoting equal attention to each of these factors can help avoid complications and side effects for patients during treatment.

Resources: The Brief Jail Mental Health Screen, developed by Policy Research Associates with funding from the National Institute of Justice, is

a booking tool for screening people in jails and detention centers to determine their needs for further mental health assessment. <https://www.prainc.com/?product=brief-jail-mental-health-screen>

- 3. Use a validated risk assessment tool:** Court staff and practitioners recommended that all courts employ one or more validated risk assessment tools as part of their screening process to determine which patients are candidates for MOUD. These could include the Clinical Opiate Withdrawal Scale,³¹ the Overdose Risk Tool,³² and others.³³

Resources: The National Institutes of Health provides risk assessment resources: drugabuse.gov.

The BJA Public Safety Risk Assessment Clearinghouse provides information on the basics of risk assessments: <https://bja.ojp.gov/program/psrac/basics>. It also provides selection resources: <https://bja.ojp.gov/program/psrac/selection>.

- 4. Prescribe within 24 hours of arrest:** Practitioners agreed that when courts prioritize making MOUD available to patients within 24 hours of arrest, it is possible to do. Staff at Syracuse Opioid Court estimated that in 90 percent of cases, patients receive MOUD the same day as their screening.³⁴ The opioid court in Rochester's Hall of Justice makes a policy of prescribing MOUD to patients within 24 hours of screening.³⁵ Both courts rely on close partnerships with prescribers to provide rapid access to all three MOUD options.

Resources: OASAS makes an online tool available to help case managers find local treatment providers: findaddictiontreatment.ny.gov.

SAMHSA provides a treatment locator with numerous filtering capabilities (e.g., for age group, insurance accepted, and special programs or groups offered for certain populations): findtreatment.gov.

The Office of National Drug Control Policy

and the U.S. Department of Agriculture provide community assessment tools: ruralcommunitytoolbox.org.

Shatterproof recently launched an online tool: Addiction Treatment Locator Assessment and Standards Platform in nine states, including New York: treatmentatlas.org.

- 5. Use the Sequential Intercept Model:** Because opioid courts operate on a pre-plea basis, the opportunity for intervention often occurs at the point of initial detention, before the first court appearance. Therefore, opioid courts must engage with community partners and patients earlier in the process. The Sequential Intercept Model (SIM) is a framework detailing how those with mental health and substance use disorders come into contact with and move through the criminal justice system. The SIM helps communities identify resources and gaps in services at specific intercepts, develop local strategies to divert people away from the justice system and into treatment, introduce community providers to evidence-based practices, and enhance relationships across agencies in order to facilitate earlier intervention.³⁶ Using the SIM can help jurisdictions plan to provide screening for MOUD needs at early intercepts—for example, in hospitals after overdoses and in police precincts after arrests—before a desk appearance ticket is issued. Practitioners recommended that justice agencies, working within federal confidentiality restrictions, seek to enhance communication and establish a continuum of care, supervision, and recovery supports with warm hand-offs when necessary. In Indiana, for example, training judges on the SIM has encouraged them to send peer advocates on police dispatch calls for patients who fail to appear in court and triage them into treatment rather than arrest them.³⁷

Offer multiple options and access points to treatment

Practitioners said that it is crucial that opioid courts offer patients access to all MOUD options that are

reasonably available in their jurisdiction. Different court participants will require different MOUD options, depending on their needs and preferences. Court staff can begin to understand the best MOUD fit by speaking with patients during the screening process. Ultimately, patients should be referred for a clinical assessment, because the choice and duration of MOUD is a decision to be made by prescriber and patient together. Prescribers must take into account a variety of factors when determining which option is best, including length of opioid use, prior treatment experience, past trials of MOUD, patient preference and characteristics, and other health issues. The decision to discontinue MOUD is based on current functioning, stabilization of withdrawal symptoms, and health issues, as well as risk of relapse and overdose. The course of MOUD may be indefinite, and full recovery can occur while patients are maintained on medication; in fact, some people do well when maintained over a lifetime.

To meet these needs, courts must consider how to form partnerships with community-based providers that are willing to prescribe each MOUD option and educate them on what justice-involved patients require. Courts should also work with a range of providers to help ensure that MOUD is prescribed equitably across patients of different racial, ethnic, and income backgrounds, which currently is not the case.³⁸ In New York State, jurisdictions provide office-based addiction treatment through a range of providers that operate in partnership with opioid courts, including federally-qualified health centers, substance use disorder programs, and other buprenorphine-waivered practitioners, like independent psychiatrists in private practice and primary care physicians. OASAS makes treatment services available by licensing opioid treatment programs to prescribe methadone and supporting outpatient programs that treat substance use disorder with buprenorphine and naltrexone. These providers, however, vary greatly in the services they provide and may not be available in every jurisdiction. Practitioners recommended the following:

1. Support buprenorphine-waivered

practitioners: Court staff reported that expanding access to MOUD, especially in remote

and rural areas, requires forming partnerships with a greater number of practitioners who have received a waiver to dispense and prescribe buprenorphine through the SAMHSA Center for Substance Abuse Treatment.³⁹ Many waived medical practitioners face barriers to prescribing.⁴⁰ Private physicians' offices may have time constraints that prohibit the prescriber from providing the services that staff would provide in a treatment program, and they may lack the expertise to address patient issues that an addiction specialist could easily address. Practitioners recommended that opioid court staff and treatment providers offer additional outreach, education, and links to services to support buprenorphine-waivered practitioners. They also recommended documenting agreements between courts and practitioners so that expectations are clear.

Resources: The American Academy of Addiction Psychiatry's Providers Clinical Support System offers free waiver trainings, clinical mentorship, and educational opportunities: <https://pcssnow.org/>.

2. Establish partnerships with local hospitals:

Working with local hospitals is a promising means for opioid courts to connect patients with MOUD more quickly. Practitioners reported that hospitals can rapidly provide buprenorphine prescription and induction to patients, directing them to further treatment resources and services from there. This can increase the number of MOUD prescribers in a jurisdiction and decrease wait times between a patient's risk assessment and referral to MOUD treatment. Syracuse Opioid Court maintains partnerships with several local hospitals that provide same-day buprenorphine access, alongside other treatment providers.

The opioid court in Saratoga is currently developing a new program to identify candidates for MOUD and treatment in the hospital after an overdose.⁴¹ Another opioid court works with local law enforcement to bring patients to the hospital where they can stabilize and

potentially receive MOUD before arrest, arraignment, and identification for referral to the court program.⁴²

Practitioners noted that these measures often require finding a champion for MOUD within the hospital, since prescribing entails challenges: hospitals must allocate staff, clinic space, and scheduling for patients with OUD. Some hospital-based physicians acknowledged that prescribers in emergency and other hospital departments express stigma against MOUD, which must be overcome with training. To meet these challenges, practitioners recommended forming a strategic partnership with a knowledgeable clinician inside the hospital who can monitor patients, identify their needs, and advocate for MOUD prescription.

3. Employ mobile prescription units: Practitioners noted that mobile prescription units, vehicles like trailers or vans that can travel to provide resources in places where people with substance use disorder need treatment, dramatically expedite MOUD prescription and other treatment interventions. Several New York State Centers of Treatment Innovation are leading the way in this area.⁴³ Buffalo City Court, where a treatment van parks outside each morning to offer on-site prescriptions, is a standard-bearer for providing rapid prescription and recovery support services within 24 hours of arrest.⁴⁴ Syracuse Opioid Court works with Helio Health, a treatment provider that uses mobile vans to assist patients in rural areas, conduct on-site assessments, and transport patients to treatment if needed. OASAS funds 96 mobile prescription units across New York State, contributing to the infrastructure available to serve opioid court participants wherever they are. Practitioners recommended expanding mobile prescription units to bring MOUD and other resources to underserved patients. Some practitioners noted that new rules for mobile units will allow them to function without a separate Drug Enforcement Agency registration,⁴⁵ streamlining the process and making them easier to establish.

4. Form partnerships with correctional institutions: Many opioid court participants receive MOUD to stabilize and later must serve sentences in jail or prison. Practitioners stressed that it is essential to patients' long-term success that they be offered the ability to continue MOUD treatment while incarcerated. State and local representatives who support opioid courts can work with law enforcement and correctional institutions to ensure that incarcerated people with OUD have access to MOUD. In New York State, OASAS, the Department of Health, and the Department of Corrections and Community Supervision (DOCCS), alongside local sheriffs and district attorneys, have worked with local jails to implement MOUD programs that offer short-acting naloxone, long-acting naltrexone, buprenorphine, and methadone when locally available. Additionally, DOCCS has initiated both methadone and buprenorphine programs for people who are incarcerated who were actively receiving those medications when the state took them into custody.

5. Make injectable MOUD options available: Injectable forms of MOUD are simpler to administer and can therefore promote better adherence. Whereas patients must take methadone doses daily, they can receive the long-acting, injectable form of naltrexone marketed under the brand name Vivitrol, or the injectable form of buprenorphine marketed under the name Sublocade, in monthly shots. Opioid courts may be reluctant to connect patients with injectable forms of MOUD because they are more expensive than other options, because there are challenges with pharmacy access, or simply because they are newer to the market and less well-known. However, some clinicians noted that Vivitrol and Sublocade can be as effective as other forms of MOUD.⁴⁶ They recommended that these forms of the medications be considered for patients, so long as courts work closely with counselors and case managers to administer treatment.⁴⁷

6. Provide telehealth access to treatment: Practitioners reported that providing telehealth

services by phone or using videoconferencing technology is a promising way to offer greater access to MOUD prescriptions and clinical check-ins for patients who have transportation or mobility limitations, child care responsibilities, full-time work, or other challenges to appearing in-person. Many treatment courts offer extensive telehealth models,⁴⁸ and these can provide remote care of the same quality as, or even better quality than, in-person appointments. Several New York jurisdictions have been operating as pilot sites for BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP). That initiative encourages drug court coordinators to use the videoconferencing platform Microsoft Teams to schedule check-ins with clients, which allows "face-to-face" interventions when a client is struggling in treatment.⁴⁹ Courts from this pilot have also been holding virtual court appearances, case management sessions, and staffings since September 2019. One site, the Dunkirk Drug Court, has been planning to add virtual links to substance use disorder services, counseling, and MOUD prescription, in addition to remote court appearances.⁵⁰ Practitioners said that videoconferencing is also an important way for better-resourced jurisdictions to provide knowledge and resources to underserved areas as they aim to build systems that provide rapid MOUD prescription.

The COVID-19 pandemic led the federal government and New York State to temporarily relax telehealth regulations, making remote access to MOUD prescription even more widely available.⁵¹ As the pandemic spread, many prescribers were forced to hold all appointments using videoconferencing platforms, a circumstance that offered important lessons. Clinicians reported that by being "creative," they could offer patients a high level of care.⁵² Prescribing medical practitioners found that they could admit new patients safely through telehealth appointments, without initial in-person contact.⁵³ To perform remote drug testing, some clinicians used saliva testing on camera or through the DynamicCare app.⁵⁴ While medical

practitioners agreed that in-person care is helpful in assessing patients and connecting them to services, they identified a group of patients who have stabilized on a longer-term basis and need only monthly telehealth check-in appointments. For patients struggling to meet treatment goals, providers simply called them more regularly. Even as social-distancing requirements relaxed, many practitioners reported an intention to continue offering broad MOUD access through telehealth. Practitioners recommended that relaxed restrictions on prescribing MOUD through telehealth services be allowed to continue after the pandemic is under control.

Resources: The National Consortium of Telehealth Resource Centers provides consultation, resources, news, and updates on telehealth at no cost: telehealthresourcecenter.org.

The Center's document *Taking Action: Treatment Courts and COVID-19* highlights some of the unique solutions treatment courts used to stay engaged with participants throughout the pandemic: <https://www.courtinnovation.org/publications/taking-action-treatment-courts-and-COVID-19>

The National Association of Drug Court Professionals provides COVID-19 resources for treatment courts: <https://www.nadcp.org/COVID-19-resources/>.

Improve coordination of services

In order to effectively provide screening and access to MOUD, practitioners agreed that close coordination between opioid courts, community-based providers, and opioid court participants is of paramount importance. In New York State, the goal of opioid courts is to develop a model of collaborative care that integrates and prioritizes medical and mental health interventions for patients at high risk of overdose. Once a participant is engaged in the court, clinicians, medical practitioners, peer advocates, and judicial staff work together to stabilize them before their legal case is addressed.

Opioid courts typically designate a leader

responsible for coordination from the beginning. Often, this is the court coordinator, who supports communication with and assigns roles among judges, court staff, court-based case managers, probation officers, treatment providers, prescribers, and patients. Court-based case managers also play a special role in representing patients by working with each partner to meet the patient's needs. Practitioners recommended the following:

- 1. Set clear expectations for providers and prescribers:** Clinicians said that opioid courts should make expectations clear to treatment providers, including the details of patients' treatment plans, the toxicology reports that will be required, and the support services that the patient will receive.⁵⁵ Many opioid treatment programs have established systems for staff to share information with opioid courts. In some cases, these are existing systems of communication created by a drug court; in other instances, the partnerships are new or evolving. This allows judges and court staff to learn, in a timely and systematic way, what successes and challenges participants are facing. Practitioners reported that office-based addiction treatment providers and other prescribers do not partake in these systems of communication as readily as treatment programs.⁵⁶ Many of those providers act as prescribers only and are not prepared to offer specialty treatment. Court staff reported that they should be expected to connect patients with trusted local substance use specialists who can make referrals for counseling and other services. Placing these expectations in writing in the form of a memorandum of understanding or other agreement helps to hold all parties accountable.
- 2. Provide education and resource sharing:** To get partners on the same page and reduce stigma, practitioners recommended providing education on the effectiveness of MOUD treatment and specific barriers. This could include training on the neurobiology of addiction, the evidence base for MOUD, the importance of coordinating care, and the implications of working with justice-involved people. Practitioners stressed the importance of training judges so that they

share standards about opioid court program participation and MOUD access. New York State provides training for all judges emphasizing that providing MOUD access is a clinical decision, not a legal one. One practitioner suggested that a training like *Our Stories Have Power*,⁵⁷ through which people who have recovered from substance use disorder share their firsthand experiences with peers, could be adapted for treatment providers and prescribers.⁵⁸ In general, practitioners emphasized that regular cross education between roles has been crucial to building the mutual understanding and orderly functioning of the state's opioid courts.

Resources: The Center for Court Innovation and the National Drug Court Institute offer training programs that can help opioid courts to implement programs, coordinate partnerships, and deliver MOUD effectively.⁵⁹

The Opioid Response Network (ORN) is a coalition of national organizations working to address opioid and stimulant use disorders by providing education and training on prevention, treatment, and recovery. Providers can receive these services at no cost after submitting a request at opiodresponsenetwork.org. Many of the recommendations in this document fall within the scope of ORN. In addition, ORN's Law and Medicine Guide supports judges and other justice-system stakeholders as they further integrate evidence-based substance use disorder treatment practices into their work. The guide focuses in part on the development of partnerships between the justice system and medical community: <https://www.aaap.org/education/law-and-medicine-guide/>

Faces and Voices of Recovery makes the *Our Stories Have Power* training publicly available: <https://for-ny.org/stories-power-train-trainer/>.

- 3. Form a therapeutic alliance with patients:** Clinicians stressed that after rapid MOUD induction, maintenance should occur as part of a sustainable recovery plan that gives patients the psychosocial support they need to continue treatment. This should include a therapeutic

alliance between counselors and patients. In supporting patients to accept beneficial counseling while they are receiving detox services, it is most helpful to approach clients before the physical symptoms of withdrawal have subsided. If patients believe that substance use is the root of their problems and do not understand holistically how it has affected their lives, they may think they need no further treatment. “What works best is having someone intervene with counseling services before clients start to feel better,” said Bob Ross, chief executive officer of St. Joseph’s Addiction Treatment and Recovery Centers in Saranac Lake, New York.

Following detox, a court-based case manager, physician, therapist, or psychiatrist can assist patients as they make choices about engaging in an MOUD treatment and a specialty care regimen tailored to their needs. Some practitioners reported having strong support from these partners for patients receiving buprenorphine and naltrexone treatment, while others lacked adequate support in the form of case managers and connections to services, especially for patients who are justice-involved. Practitioners said that treatment conferences—regularly scheduled meetings between the various agencies supporting a patient—are an important way for agencies to collaborate regarding a patient’s treatment and goals and thereby effectively support their recovery.

- 4. Offer specialty care:** Patients often need an array of therapeutic and social services in addition to MOUD. Practitioners noted that while private physicians are a good resource for writing prescriptions, they lack the structure that OASAS outpatient programs can offer. Many recommended that patients be directed to these programs and treatment facilities. While outpatient programs vary greatly in the services they provide, they typically have a core structure that offers individual and group therapy, and they may also include services like physical examinations, one-on-one counseling, housing referrals, and employment assistance.

- 5. Integrate community support services:** A variety of community support structures help patients to stabilize within their treatment plan, reintegrate into the community, and recover from opioid use disorder on a long-term basis. These include traditional social services, like mental health treatment, housing assistance, employment placement, education, and family reunification. They also include services specific to substance use disorder, like recovery community organizations, peer advocates, twelve-step recovery programs, and other mutual support groups that link patients to resources and social connections with people in long-term recovery. This helps treat the isolation that is endemic to substance use disorder. Harm reduction experts agreed that communities and providers should employ a range of measures to keep patients engaged over time along a continuum of care.⁶⁰ Practitioners recommended persistent outreach to patients from professionals, peer advocates, and family to keep them connected to their MOUD regimen, treatment program, and community.

Integrate support from peer advocates

Peer advocates are frontline practitioners, sometimes with lived experience of justice involvement and long-term recovery from substance use disorder, who are trained and certified to serve as liaisons between opioid courts, clinicians, and participants. Practitioners recommended integrating peers into opioid courts. A significant body of research shows that including peer advocates’ services in treatment courts and other programs improves program completion rates and reduces recidivism among participants.⁶¹

Often, peers can help prepare a person for court, set realistic expectations, explain the process in straightforward terms, and discuss the challenges of opioid court and MOUD treatment. Peers who have recovered from substance use disorder can put their story and experience at the forefront of their connection with the people they work with in a way

that clinicians often cannot because of their clinical role. Peers also serve as a crucial conduit to mutual support groups like 12-step programs and social services like resume development and employment assistance. Perhaps most importantly, peers can provide people with an example of another person who has recovered from substance use disorder.

In New York State, many peers are linked to OASAS-funded recovery community organizations, through which they can provide in-house services. Others are connected to grassroots community-based organizations. Practitioners reported several challenges in working effectively with peers, including poor understanding of what they do, bias against them, and employment arrangements and funding streams that present barriers. As a result of COVID-19, the field faces additional challenges, with peers and their employers “scrambling” to develop protocols for reaching people with substance use disorder, to use one practitioner’s word.⁶² Practitioners recommended the following:

- 1. Provide training for peer advocates:** The certification board at the Alcoholism and Substance Abuse Providers of New York State (ASAP) certifies peers as Certified Recovery Peer Advocates. Certification establishes that a peer advocate has been trained on and possesses a standard set of competencies delineated by subject matter experts. Some recovery community organizations offer training for this certification. ASAP has developed specialized certifications for peer roles to work with veterans, families, and youth, each of which requires specialized training. Practitioners recommended creating a specialized role for peers on working within the opioid court context and with patients who have co-occurring disorders.

Resources: ASAP provides listings of approved roles, trainings, and trainers: <http://www.asapnys.org/ny-certification-board/nycb-approved-training/>

- 2. Create systems for integrating peer advocates into opioid courts:** Technical assistance providers have recommended several measures to take when integrating peers into opioid

courts, including planning a menu of services; setting policies and procedures; scheduling check-ins between courts, providers, and peers; and promoting recovery orientation among stakeholders.⁶³ Practitioners noted that court staff could benefit from special training and protocols to clarify the relationship between courts and peers. These could include using a group tracking model to supervise the work of peers, creating an onboarding process specific to courts, developing an overview of peer training to help other partners understand the ethics of the profession, and inviting peers to community meetings with recovery community organizations.⁶⁴

Resources: Altarum, a technical assistance provider for opioid courts under COSSAP, has developed *Peer Recovery Support Services in New York Opioid Intervention Courts: Essential Elements and Processes for Effective Integration*, a forthcoming publication and curriculum on integrating peers into opioid courts: <https://altarum.org/>.

Use innovative business models to secure sufficient reimbursement

In New York State, all health insurers are required to cover all three MOUD options.⁶⁵ Medicare offers adequate coverage, fully reimbursing take-home doses of buprenorphine and methadone as well as opioid treatment programs through bundled payments for OUD treatment services.⁶⁶ Rules under Medicaid have also changed in recent years to make it more feasible for providers to offer all federally approved medications for treating substance use disorder. Practitioners agreed that marketplace insurers are still on a learning curve for reimbursing treatment programs, and it can at times require more staff effort to receive reimbursement. Practitioners recommended the following.

- 1. Extend prescribing to new sites:** New York State has recently put measures in place to assist MOUD-prescribing providers with reimbursement. A 2018 statewide plan mandates insurance reimbursement for in-community addiction services rendered by outpatient

providers. OASAS authorized community-based outpatient providers to deliver these services on site—that is, outside of the providers’ offices. Practitioners recommended that treatment counselors and other providers consider extending MOUD prescribing and treatment services for OUD into more primary care physician sites and other, less commonly used community spaces where they will receive full reimbursement.

Resources: OASAS has committed to help manage the challenges of this expansion and makes information publicly available⁶⁷: <https://oasas.ny.gov/system/files/documents/2019/05/CoverageforCommunityServices5.18.18.pdf>.

2. Form agreements with opioid treatment programs and providers:

Practitioners noted that opioid courts have an advantage when seeking to attract opioid treatment programs and providers. Despite the varying rates they may collect from Medicaid and private insurance, opioid courts help them gain regular referrals, fill spots, and get reimbursed for services. Drug courts also have a higher retention rate over time than community-based treatment programs alone,⁶⁸ which means that providers see patients more consistently. This can require that providers add staff and clinical support to manage patients using MOUD. In some jurisdictions providers work with local treatment programs to share resources and responsibilities.⁶⁹ In New York City, practitioners noted that NYC Health and Hospitals along with other providers offer great capacity for office-based buprenorphine delivery. Some suggested that this system could be streamlined to make MOUD available to more patients.⁷⁰

3. Pilot the Massachusetts Model: Practitioners suggested that opioid treatment programs consider piloting the Massachusetts Model, currently under trial in Boston, which has aimed to help scale up MOUD access for people with OUD.⁷¹ Using this approach, nurse care managers form partnerships with physicians who assess patients and prescribe MOUD. The nurse care

managers address their needs related to OUD, much as they would for patients with other chronic medical conditions. The model allows office-based addiction treatment providers to see more patients, assists with reimbursement, and maintains cost-effectiveness at larger scales,⁷² which expands access to MOUD and ongoing care in the context of opioid courts.

Resources: The Boston Medical Center hosts an office-based addiction treatment training and technical assistance program through which providers can receive assistance with implementing the Massachusetts Model: <https://www.bmcobat.org/>

4. Consider using the “hub-and-spoke” model:

Practitioners recommended that states consider adapting the “hub-and-spoke” business model to streamline the workflow and funding arrangements between treatment programs and prescribers.⁷³ Developed in Vermont, it aims to increase MOUD access through opioid treatment programs by linking patients to community-based health care providers in remote areas, often through telehealth platforms, once they are stabilized and meet certain criteria. Under the model, patients see a specialist at a treatment program, a “hub,” for MOUD induction; when patients meet certain criteria, they are then referred to a community-based provider, a “spoke,” for further services.⁷⁴ The model, which allows people with OUD to be linked to care expediently while Medicaid pays for the benefits, could help connect underserved opioid court participants to treatment.

Resources: The State of Vermont’s Blueprint for Health website contains implementation materials for the hub-and-spoke model: <https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke>.

5. Reimburse the services of peer advocates:

Practitioners stressed the importance of building a business model and reimbursement structure for peer advocates, not just clinicians. When peers are employed by an opioid treatment

program, they can be incorporated into a patient's treatment plan and reimbursed through Medicaid, a measure that helps make their services accessible. However, when peers are employed by recovery community organizations or other community-based organizations they typically provide services in-house, are not part of a treatment program, and cannot be reimbursed. This structure also means that when a patient is discharged from a treatment program, they often lose access to the peer with whom they have been working. Practitioners said that a better model would allow any organizations that employ peers to be reimbursed for peers' work with treatment providers, as case managers are.

Resources: *The Peer Integration and the Stages of Change Toolkit*, published by OASAS, provides a comprehensive guide on how to integrate peers into treatment programs: <https://oasas.ny.gov/system/files/documents/2019/08/PeerIntegrationToolKit-DigitalFinal.pdf>.

- 6. Continue to allow prescriptions for new patients through telehealth platforms:** During the COVID-19 pandemic, the reimbursement structure was temporarily changed. Whereas, in the past, providers could be reimbursed for MOUD prescriptions only after first seeing a patient in person, during the pandemic they could prescribe MOUD to new patients they saw first through telehealth platforms. A phone call initiated by a patient could also be reimbursed at the same rate as an office visit. This created a strong incentive for providers to serve patients in need of MOUD and for patients to seek their services. Many providers reported that this improved their ability to assist patients. It especially helped them overcome barriers for patients in remote areas and those who face challenges to making in-person appointments. Providers recommended that these relaxed reimbursement structures for prescribing MOUD through telehealth services continue beyond the pandemic.

Track outcomes

In order to evaluate the effectiveness of MOUD delivery, New York State opioid courts collect a variety of measurements to track patients' success. These include tracking long-term outcomes in the court population pre- and post-implementation, outcomes for program graduates compared to non-graduates, and outcomes across different areas of the treatment system. This helps the state, OASAS, and opioid courts to understand whether court programs are being implemented effectively. Practitioners recommended the following.

- 1. Measure recurrence, overdose, and death:**

Many opioid courts, opioid treatment programs, and providers conduct and track routine drug call backs to ensure that patients are using MOUD as prescribed. They also conduct toxicology screens to detect recurrence of opioid use. Clinicians and OASAS intend that these practices be used therapeutically and not punitively, despite the fact that recurrence has legal implications.⁷⁵ Most courts also track occurrences of patient overdose and death from the date patients were discharged from a treatment program as well as their last date of treatment contact.

- 2. Use written agreements:** Practitioners indicated that tracking these measures collaboratively over time across multiple agencies typically requires that the partners adhere to written data agreements. Often, the court coordinator is tasked with maintaining data on patient success. Some virtual platforms that courts use, such as Kaden Health, store reports on patients' toxicology, adherence to therapies, appointment attendance, and other metrics, making it simple for all authorized partners to access and track. Opioid courts can use these data to evaluate program success overall.

3. Consider tracking other metrics: Practitioners noted that the field of MOUD in opioid courts is relatively new and much remains unknown. In New York State, the UCS is participating in the Overdose Detection Mapping Application Program (ODMAP) to track local instances of overdose with a goal of addressing service gaps in communities with a high incidence of overdose. Some practitioners suggested that courts collect data that could help answer larger research questions. For example, how do courts know which program components are effective and which are not? Can some components negatively affect certain patients, especially those facing homelessness, co-occurring disorders, or criminal justice involvement? To what precise degree does opioid court participation reduce the incidence of overdose and death?⁷⁶ Collecting data on these and other metrics can contribute to the knowledge of the field and help practitioners build a better understanding of what works.

Resources: ODMAP provides nearly real-time data on suspected overdoses to support justice system and public health efforts to address local spikes in overdose events: <http://www.odmap.org/>.

III. Conclusion

When administered along with other services, MOUD is a highly effective treatment for the pervasive problem of opioid use disorder. (OUD) The experience of opioid courts in New York State has shown that patients stand a stronger chance of full recovery when courts provide medication for opioid use disorder (MOUD). The interviews conducted to produce this report were an opportunity to explore the best ways to use the opioid court context, and the many interagency partnerships it fosters, to deliver MOUD to patients facing special vulnerability, risk, and stigma due to OUD and criminal justice involvement. Speaking with practitioners from across disciplines yielded important lessons about how courts and their partners have shifted practices to serve the needs of such patients expediently while also remaining viable as businesses.

The COVID-19 pandemic created challenges that dramatically affected the people and institutions of the state, not least of which were its criminal justice-involved population, patients with OUD, and the providers charged with treating them. In their rapid response to these challenges, opioid courts and their partners demonstrated that the model is capable of adapting and improving its ability to deliver MOUD to patients who face the greatest need. Practitioner insight shows how MOUD can be used both in ordinary times and during a crisis to prevent overdose, save lives, and set patients on a path toward long-term recovery from OUD.

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