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Medication-Assisted Treatment (MAT) in Drug Courts: Addressing Barriers to Effective Implementation

Jill Harrington, B.S.N., R.N., CCHP-RN, *Health Services Administrator, Albany Cnty. Correctional and Rehabilitative Services Center* ***(JH)***

Mark H. Duncan, M.D., *Assistant Professor, University of Washington* ***(MD)***

Hon. Shaun R. Floerke, J.D.,*District Court Judge, 6th Judicial District of Minnesota* ***(SF)***

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Q1: Can you talk about treatment benefits or challenges for facilities beginning to use buprenorphine (Subutex) instead of buprenorphine-naloxone (Suboxone)?

JH: One of the challenges for us has been that people report allergies to naloxone. Suboxone is less likely to be abused or diverted due to the naloxone component. In the event that an individual was to inject an opioid, it would cause immediate precipitated withdrawal, thus buprenorphine would be preferred.

MD: In general, there is no significant clinical benefit to using buprenorphine over buprenorphine-naloxone. While buprenorphine, on its own, is associated with higher rates of diversion and injection in community settings, the research does not indicate its use would necessitate increased monitoring compared to what is done with buprenorphine-naloxone within a controlled setting, such as a correctional facility.[1]

Q2: How does one get a provider at local jail to change their mind about prescribing buprenorphine?

JH: Education and invitations to discussions surrounding MAT. Offer statistical data showing the efficacy of successful programs.

MD: Consider bringing in some technical assistance from other correctional facilities to talk about their experience using buprenorphine for opioid use disorder (OUD) treatment and to answer any concerns or questions that provider may have. It can also be helpful if the jail staff and jail administration voices support for using buprenorphine-naloxone for OUD. Finally, there is a growing national consensus around providing OUD treatment with buprenorphine-naloxone as well as several resources that outline current practice guidelines for treating OUD in correctional facilities that may be helpful to distribute.[2,3,4]

SF: Seek to partner with the provider to develop this important resource. Share the data about outcomes and the dangers of not allowing MAT. Share stories of successful clients elsewhere. This will be a common theme, but educate them and ensure they have all the relevant information.

Buprenorphine has as an ingredient that deters misuse, but must be taken orally. It is a partial agonist, meaning it prevents withdrawals or cravings, it is unlikely to be misused because it does not contain a potent opioid, and it does not require a complete detox before starting, unlike Vivitrol.

The benefits are myriad, such as reducing costs of other medical treatments, increasing employment, decreasing the risk of relapse the longer it is used, and increasing the participation in outpatient mental health counseling, to name a few. If the jails see that the costs will decrease and the likelihood of the individual's return is low, they are incentivized to permit the use, especially since approximately a quarter of heroin-addicted people enter the U.S. justice system each year, and approximately half of state and federal people in prison have substance use disorders.[5,6]

Q3: We have very low participation in the naltrexone (Vivitrol) program because of client resistance. What can we do to overcome this resistance?

JH: Educate clients on long-term protection and avoidance of daily dosing. We have found most patients do not like the injection due to reported pain and side effects.

MD: Consider asking the clients themselves why they are not participating in this program. There are many reasons why people do not engage in treatment that can include: not wanting to take extended-release naltrexone, overly restrictive requirements, or a stigmatizing environment. In addition to

reviewing what clients would like to see in a treatment program, offering both buprenorphine-naloxone and extended-release naltrexone, and taking a more harm-reduction stance to treatment will all promote engagement.

SF: I assume that you are offering all three types of MAT? If not, I'd suggest expanding options. There are solid reasons folks will choose one type of MAT over another or choose not to engage in MAT altogether (availability, barriers, access, cost, effects, etc.). Ultimately, the individual retains informed choice over their options. We can educate, explain, support, and offer options but ultimately the person has choice.

Q4: I have difficulty getting upstate New York programs to provide MAT to clients from New York City. How do you overcome county insurance issues?

JH: : From what we have seen, the insurance goes through the county of the person's residence. Locally, the person can be referred to Albany County Department of Social Services for food stamps, but housing and medical insurance would be handled by the person's county of permanent residency.

Q5: For people on probation who are receiving MAT, how can we balance the need to continue MAT in jail for times when incarceration may be necessary?

JH: More and more correctional facilities are beginning to offer MAT or at least continuation of MAT. The risk for withdrawal while incarcerated and overdose when released to the community is extremely high if MAT is not continued, so it is beneficial for the person to continue MAT, if at all possible. Keeping open lines of communication with probation, parole, and drug courts is essential.

SF: Jails should provide MAT. Even before ours did broadly, we had policies and procedures in place for several years whereby our clients could continue MAT for the 24–48 hours of flash incarceration. If you are using more jail than that we can point you to additional training. Incarcerating individuals knowing that they will go into withdrawal from their medication and face serious risks of overdose and death upon release should be very, very cautiously considered and only used in exceptional circumstances. MAT is one of the most effective methods of preventing relapses, more effective than counseling alone or 12-step groups such as Narcotics Anonymous.[7]

Though there are not many cases, people have sued and are suing over being unable to use MAT in jails, including in the military (United States v. Walker, 2013 WL 1318503, unpublished). There are two recent federal cases:

- **Smith v. Aroostook**, 376 F.Supp.3d 146: Americans with Disabilities Act (ADA) claim made for not being allowed to continue MAT in a correctional facility; denial of necessary, prescribed medication determined to be unreasonable—inferred county denied request because of disability, especially given county's general attitude toward addiction.
- **Pesce v. Coppinger**, 355 F.Supp. 3d 35: ADA and Eighth Amendment claims for being denied MAT in jail; likely to succeed; "absent medical or individualized security considerations underlying the decision to deny access to medically necessary treatment, Defendant's policy as applied to Pesce is either arbitrary or capricious as to imply that it was pretext for some discriminatory motive or discriminatory on its face." Defendants' blanket policy to prohibit methadone ignores Pesce's doctor's recommendations and prescriptions, so his Eighth Amendment claim is likely to succeed.

Q6: I have seen drug court participants being encouraged by the treatment team to keep their use of buprenorphine-naloxone (Suboxone) secret from other participants in drug court, lest they encourage others to use MAT. How do we destigmatize MAT in this scenario?

JH: I think the biggest issue is the lack of education about MAT, its uses, and its benefits. We have invited drug court teams to our monthly MAT meetings and try to keep open communication with them on participants, programs, and outcomes. We have presented data on the success of our program to them to help alleviate fears of having clients on MAT.

SF: I would educate the treatment team on the value of MAT, the life-saving capacity of MAT, and the vastly improved outcomes for clients on MAT. If the treatment team resists education, I'd consider replacing the team members. Honestly, I think we need to educate folks but then expect folks to follow the research and best practices. People's lives are literally at stake here.

Q7: There are differences in retention rates on the three different types of medications, with extended-release naltrexone being the lowest. Yet these are the medications that seem to be most accepted by drug courts. Any recommendations about shifting ways of thinking about agonist medication?

JH: The primary reason it is preferred is because it has the lowest misuse potential. Provide education, openly communicate with the courts, and present case studies of successful programs using agonist medication.

MD: Consider talking about the importance of meeting the community standard for OUD treatment, which includes offering buprenorphine-naloxone in addition to the other medications. Also, consider reviewing the emerging evidence that show lower rates of opioid overdose, lower rates of

opioid-related acute care, and improved mortality rates for buprenorphine-naloxone and methadone, but not for extended-release naltrexone. Finally, buprenorphine-naloxone has more evidence for treating the largest spectrum of patients, including adolescents and pregnant women, which is not the case for extended-release naltrexone.[8,9,10,11]

SF: Educate, provide research and best practices, and hold people accountable to best practices. As more medications become available, recommend the ones with higher retention rates. There isn't necessarily a great way to shift thinking immediately, or even soon, but it can be done gradually through recommending medications that have higher retention rates. Methadone is the oldest Food and Drug Administration-approved medication for opioid-addiction and is the most well-known medication, but even methadone has a strong stigma today; it takes time to change minds.[12,13]

Q8: Can we deny a participant's choice of MAT if that participant has misused a particular medication during previous drug treatment court participation?

JH: Our local drug courts evaluate on a case-by-case situation. While it is not up to the court to make the decision of whether MAT is prescribed or which drug is prescribed, the judge/court will have the participant sign a participation agreement and evaluate them frequently for compliance via arrests, drug testing, etc. The judge will issue warnings and offer interventions (e.g., weekend sentence in jail, community service, write an essay) for non-compliance with the program and document those interventions.

SF: I would be reluctant to interfere with the physician-client relationship any more than I would with regard to patient choice with other medications. However, I would hold my client accountable to showing that he or she is properly using any medication, including MAT.

Q9: If a patient is in a residential treatment program and does not want to participate in MAT, is it legal to discharge the patient for non-compliance with medication?

JH: As far as I know, each program can make their own determinations as to the qualifications/criteria for a program. Most will not discharge a patient for non-compliance with medication if they choose not to take it. However, if they are diverting the medication for other reasons (selling), this would change the reason for discharge. Other solutions for treatment would be offered (e.g., counseling, peer programs).

Q10: In order to participate in drug court in my area, a person may be required to sign a document stating they will not enroll in MAT. Can a person enrolled in a MAT program while participating in drug court be held accountable for violating terms of the drug court?

JH: In our area, a patient enrolled in a MAT program may participate in drug court. They are still subject to monitoring, such as drug testing. Our courts do not have them sign any documents stating they will not enroll in MAT. This decision is made by the patient's own healthcare provider.

SF: I believe this is likely unconstitutional and it is clearly a dangerous/deadly practice to deny a client access to proven, effective medical care and treatment. The drug court must change its policy/practice. Drug courts operate on principles that include access to a continuum of alcohol, drug, and other rehabilitation resources, of which MAT is one. The Office of National Drug Policy indicated that if a drug court receives federal funds, the court must ensure access to MAT.[14]

Q11: Are there standard medication dosages for drug court-referred MAT participants?

JH: No, the courts do not dictate dosages of MAT participants. These are determined by the patient's physician. However, if the courts see that the person appears over-medicated or under the influence of other substances, they will make recommendations to the person's prescriber.

Q12: Who will cover/pay for the MAT services while the client is in drug court? Does health insurance cover this?

JH: In our area, the patient will be referred from either drug court or the originating prescriber or clinic to NY Health or be connected with a navigator in the community to enroll in Medicaid. Medicaid does cover MAT services in the State of New York.

SF: Our clients on insurance from the State of Minnesota are eligible for suboxone and methadone coverage. Vivitrol is not covered by Minnesota insurance. Coverage by private insurance (rare for us) varies.

Q13: Are there any standardized forms for MAT, such as release of information forms and waivers?

MD: Standardized forms for MAT can be found at the following websites:

- → Providers Clinical Support System
- → Boston Medical Center Office Based Addiction Treatment Training and Technical Assistance

Q14: Can you provide information on how to interpret buprenorphine levels in urinalysis testing to determine if misuse is occurring?

MD: Buprenorphine levels can help identify potential tampering of urine drug screens, but the evidence base supporting buprenorphine level interpretation is still growing, and cut-offs are being defined. One small study suggests a total buprenorphine level of greater or equal to 700 ng/mL had a specificity of 85 percent for detecting urine adulteration. In general, a pattern of unusual quantitative buprenorphine urine levels needs to be carefully interpreted within an individual and their broader clinical pictures. Buprenorphine dose and urine levels of buprenorphine and norbuprenorphine do not correlate well and should not be used.[15,16]

Q15: How long should a patient stay on Vivitrol or naltrexone?

MD: Similar to buprenorphine and methadone, there is no evidence base that describes an optimal duration of treatment for an individual. As with all medications for OUD treatment, including extended release naltrexone, the risk of returning to drug use and mortality will dramatically increase when a patient stops taking these medications. They should be continued for as long as the patient finds them helpful, which could be years.

Q16: We have participants whose MAT costs over $500 a day. Are there funds besides health insurance available to pay for medication?

MD: MAT costs can vary depending on the medication used, with extended-release naltrexone typically costing the most (greater than $1,000/month) because it is not generic. Methadone and buprenorphine-naloxone tablets/films are now generic. Non-insurance funding is limited and variable for OUD treatment medications from location to location, but can include the 340B Drug Discount Program, manufacturer discounts such as patient-assistance programs, and the GoodRx.com discount. It is often best to call up the pharmacy you are working with to talk through what the most affordable options to prescribe are.

Q17: Are there MAT options for methamphetamine users?

MD: Medication treatment options for methamphetamine have shown no effects to modest and inconsistent effects in clinical trials around maintaining abstinence, reducing overall use, and retention in treatment. Of the medications studied, methylphenidate did the best, showing subtle effects on reducing use, but did not impact treatment retention when compared to placebo. Mirtazapine has also shown some modest benefit in reducing methamphetamine use in a population of men who have sex with men, but no impact on treatment retention. Overall, first-line treatment for methamphetamine use disorders are psychosocial interventions with medication treatment considered a supplemental strategy to support psychosocial interventions.[17]

About

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation focuses on expanding access to services for people with mental and/or substance use disorders who come into contact with the justice system.

Contact Us

SAMHSA'S GAINS CENTER
Policy Research Associates
345 Delaware Avenue
Delmar, NY 12054

Phone: 800.311.GAIN
Email: gains@prainc.com

Endnotes

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