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

Douglas B. Marlowe, JD, PhD
Steve Hanson, MSEd, LMHC, CASAC
Shaun R. Floerke, JD

February 24, 2020
12:30-2:00pm ET

Hosted by SAMHSA's GAINS Center

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Substance Abuse and Mental Health Services Administration

Welcome and Housekeeping

Lisa Callahan, PhD
Senior Research Associate II
Policy Research Associates, Inc.

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Agenda

Welcome	**Lisa Callahan, PhD** *Policy Research Associates, Inc.*
Opening Remarks	**Jon Berg** *Senior Public Health Advisor, SAMHSA*
Presentation	**Douglas B. Marlowe, JD, PhD** *Senior Scientific Consultant* *National Association of Drug Court Professionals* **Steve Hanson, MSEd, LMHC, CASAC** *Associate Commissioner* *Courts and Criminal Justice, NYS Office of Alcohol and Substance Abuse Services* **Shaun R. Floerke, JD** *District Court Judge* *6th Judicial District of Minnesota*
Questions **Closing Remarks**	**Lisa Callahan, PhD** *Policy Research Associates, Inc.*

Opening Remarks

Jon Berg

Senior Public Health Advisor

Center for Substance Abuse Treatment

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Introducing Today's Presenters: Douglas B. Marlowe, JD, PhD

- Is Senior Scientific Consultant for the National Association of Drug Court Professionals (NADCP), and Senior Science & Policy Advisor for Alcohol Monitoring Systems (AMS).
- Formerly served as Chief of Science, Law & Policy for NADCP; Director of Law & Ethics Research at the Treatment Research Institute (TRI); and Adjunct Associate Professor of Psychiatry at the University of Pennsylvania School of Medicine.
- Is a lawyer and clinical psychologist who studies the effects of treatment courts and other rehabilitation programs for persons with substance use and mental health disorders in the justice system.
- Published over 175 journal articles, monographs, books, and book chapters on the topics of correctional rehabilitation, forensic psychology, and treatment of substance use disorders.
- Serves as Editor-in-Chief of the *Journal for Advancing Justice,* is on the editorial board of *Criminal Justice & Behavior*, and was previously Editor-in-Chief of the *Drug Court Review.*

Introducing Today's Presenters: Steve Hanson, MSEd, LMHC, CASAC

- Is the Associate Commissioner for Courts and Criminal Justice for the New York State (NYS) Office of Alcoholism and Substance Abuse Services.
- Served previously as the NYS Associate Commissioner for Treatment, overseeing treatment services in the state of New York, including direct oversight of 12 state-operated inpatient treatment programs.
- Has been on the faculty of the National Drug Court Institute at NADCP since 2001.
- Has presented both nationally and internationally on the topics of Addiction and Treatment.

Introducing Today's Presenters: Shaun R. Floerke, JD

- Is a district court judge of the 6th Judicial District of Minnesota, chambered in Duluth, MN.
- Founded and presides over the South St. Louis County DWI Court in Minnesota, one of four National Center for DWI Courts Academy Courts in the nation.
- Is a member of the National Judicial Opioid Task Force and serves on the Judicial Advisory Board for the Foundation for Advancing Alcohol Responsibility.
- Is the founding and presiding judge of the Duluth Domestic Violence Restorative Circles Intervention in Duluth, MN.
- Serves as Co-chair of the Minnesota Treatment Court Initiative.
- Is a faculty member and trainer for the National Center for DWI Courts and the National Council of Juvenile and Family Court Judges.

Resolving Barriers to Medication-assisted Treatment (MAT) in Treatment Courts

Douglas B. Marlowe, JD, PhD
Senior Scientific Consultant
National Association of Drug Court Professionals

February 24, 2020

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Standard of Care

MAT is the Standard of Care for Treating Opioid Use Disorders:

U.S. Dept. of Health & Human Services (1997)

National Institute on Drug Abuse (2014, 2018)

U.S. Surgeon General (2018)

Substance Abuse & Mental Health Services Administration (2005, 2018)

National Academy of Sciences, Engineering & Medicine (2019)

World Health Organization (2004)

Centers for Disease Control & Prevention (2002)

American Medical Association (2017)

American Psychiatric Association (2017)

American Society of Addiction Medicine (2015)

American Academy of Addiction Psychiatry

American College of Obstetricians & Gynecologists (2016)

National Association of Drug Court Professionals (2010, 2013, 2015)

Etc. . .

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Effectiveness in the Criminal Justice System

Domains	Methadone	Buprenorphine	XR-Naltrexone
Withdrawal symptoms	√	√	N/A
Opioid cravings	√	√	√
Treatment entry & retention	√	√	√
Illicit opioid use	√	√	√
Criminal recidivism	N/A	N/A	√
Overdose risk	√	√	√
Other health risk behaviors (e.g., sharing syringes; unprotected sex with multiple partners)	√	N/A	√

(SAMHSA, 2019)

√ at least two meta-analyses, systematic reviews or experimental trials in criminal justice populations

√ experimental trials in non-criminal justice settings or correlational studies in criminal justice populations

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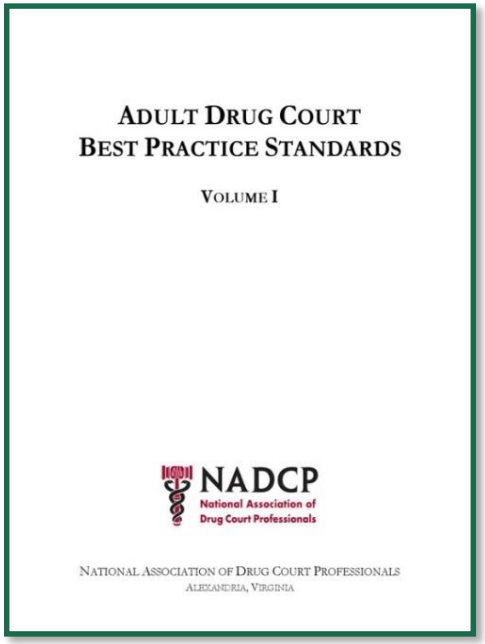
NADCP Best Practice Standards

- Obligation to learn the facts about MAT
- Obtain medical consultation
- No blanket prohibitions for entry or graduation
- Particularized factual inquiry
- Reviewable record and rationale



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Minimizing Medication Misuse and Diversion

- Observed administration
- Medication level monitoring
- Pill counts
- Medication event monitoring (e.g., MEMS, smart phone apps)
- Misuse-deterrent formulations
- Pre-approval, disclosure and release of information for new prescriptions
- Prescription drug monitoring programs (PDMPs)

Failure to abide by these conditions is a proximal (willful) infraction, and merits a higher-magnitude sanction.

Prescription Drug Monitoring Programs (PDMPs)

<u>Mandatory reporting</u> to PDMPs is associated with:

- Fewer dangerous medication interactions.
- Fewer overlapping prescriptions for the same medication.
- Fewer patients obtaining prescriptions from 5 or more doctors or pharmacies ("doctor shopping").
- Fewer refill authorizations of 7 or more months for controlled medications.
- 3 - 4% decrease in overall crime rates.
- 5 - 7% decrease in violent crime rates.
- Mixed evidence of impact on opioid overdose and mortality, largely attributable to increased use of illicit opioids (e.g., heroin).

(SAMHSA, 2019)

PDMPs (cont'd)

Mandatory inquiries might produce even better effects.

- Drug courts should require inquiries in their memoranda of understanding (MOUs) with providers.

Information about your state or territory's PDMP

PDMP Training & Technical Assistance Center

- Is PDMP enrollment mandatory or permissive in your jurisdiction?
  - *Mandatory enrollment for N=44 (83%) of prescribers, dispensers or both as of Jan, 2019*
  - *Enrollment conditions by state*
- Must providers query the PDMP for new covered prescriptions or refills?
  - *N=45 (85%) of states required inquiries as of Jan, 2019*
- Data-sharing reciprocity with other jurisdictions.
  - *Interstate data-sharing partners*
- Data-sharing with law enforcement, community corrections and drug courts.
  - *Approx. one-third of states explicitly authorize reports to drug courts*
  - *Law enforcement access methods to PDMP reports*
  - *Solicited and unsolicited reports to law enforcement agencies*

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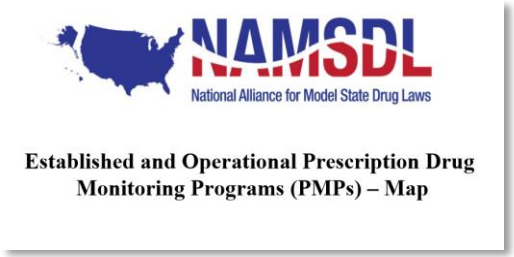
Information about your state or territory's PDMP

- National Alliance for Model State Drug Laws



https://namsdl.org/wp-content/uploads/Established-and-Operational-Prescription-Drug-Monitoring-Programs-PMPs-–-Map.pdf

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Authorized MAT Providers

- Methadone may only be prescribed or dispensed for the treatment of substance use disorders from a licensed opioid treatment program (OTP).
  - Take-home doses may be permitted after meeting legally specified requirements for treatment attendance, clinical stability, and abstinence from illicit substances.

(SAMHSA, 2015)

Authorized MAT Providers (cont'd)

- Buprenorphine (e.g., Suboxone, Subutex, Probuphine, Sublocade) may only be prescribed by a DATA-2000 waivered medical provider.
  - Physicians must complete an 8-hour training and can treat up to 100 patients in the first year and 275 patients thereafter.
  - Nurse practitioners and physician's assistants must complete a 24-hour training and can treat up to 100 patients.
  - Only about 5% of physicians have obtained DATA-2000 Waivers.
- Naltrexone (including Vivitrol) may be prescribed and dispensed by licensed medical providers such as physicians, physician assistants, and nurse practitioners.

(SAMHSA, 2019; National Drug Court Institute, 2013; SAMHSA, nd)

Finding Local MAT Providers

- SAMHSA Behavioral Health Treatment Services Locator
- SAMHSA Buprenorphine Practitioner Locator
- SAMHSA Opioid Treatment Program Directory
- American Academy of Addiction Psychiatry (AAAP)
- American Board of Addiction Medicine (ABAM)
- American Society of Addiction Medicine (ASAM)

Most can be queried by state, county or zip code to find providers near you

Providers may also be found through single-state agencies for substance use services, local colleges & medical schools, or county or state boards of health.

Buprenorphine Waiver Courses & Applications

- SAMHSA Buprenorphine Training for Physicians
- SAMHSA Buprenorphine Waiver Management
- American Association of Nurse Practitioners (AANP)
- ASAM eLearning
- Providers Clinical Support System (PCSS)

Screening and Referral

- All participants should be screened routinely for symptoms of opioid use disorder, including current and past opioid use, withdrawal symptoms, cravings, overdose history, opioid treatment history, and past receipt of MAT.
- Any person screening positive should be referred to a licensed and trained medical provider for a follow-up diagnostic evaluation and determination of suitability for MAT.

(SAMHSA, 2015)

Examples of Brief Screening Tools

- **Symptoms of Opioid Dependence**
  - Texas Christian University (TCU) Drug Screen-5-Opioid Supplement
  - Rapid Opioid Dependence Screen (RODS)
  - Severity of Opioid Dependence Questionnaire (SODQ)
- **Withdrawal Symptoms**
  - Clinical Institute Narcotic Assessment (CINA) Scale for Withdrawal Symptoms
  - Clinical Opiate Withdrawal Scale (COWS)
  - Subjective Opiate Withdrawal Scale (SOWS)
- **Cravings**
  - Brief Substance Craving Scale (BSCS)
  - Heroin Craving Questionnaire (HCQ)
  - Opioid Craving Scale (OCS)
- **Overdose Risk**
  - Current Opioid Misuse Measure (COMM)
  - Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)

Peer Support Groups

- Narcotics Anonymous (NA, 2016) policy is accepting of MAT, including agonists (methadone and buprenorphine); however, many groups disapprove of MAT or discourage entrance for those receiving it.
- In a recent study, 58% of drug court participants reported experiencing or witnessing disapproval of MAT from peer-support group members (Gallagher, Marlowe et al, 2019).

Peer Support Groups (cont'd)

- Preparing participants for possible disapproval and discussing how and whether to share their receipt of MAT increases group satisfaction and tenure (Galanter, 2018; Krawczyk et al., 2018; Suzuki & Dodds, 2016; White et al., 2013).
- Peer-support groups accepting of MAT can be found at Medication-Assisted Recovery Anonymous (MARA).

Paying for MAT

- Over 1,200 federally qualified health centers (FQHCs) offer buprenorphine at discounted rates (urban and rural areas).
- Many drug courts negotiated reduced rates from pharmaceutical companies.
- 340B Drug Discount Program requires drug manufacturers participating in Medicaid to provide medications at significantly reduced prices to “covered entities”. Patients do NOT have to be covered by Medicaid.

(SAMHSA, 2019)

Paying for MAT (cont'd)

- **Medicaid:** Drug court participants and people on probation are fully eligible.
  - As of 2/2018, 36 states and territories covered methadone, 51 covered buprenorphine, 49 covered naltrexone, and over 50% increased coverage for naloxone (Narcan).
  - There is discretion to cover "rehabilitative services", broadly defined to include substance use counseling, peer support specialists, supportive housing, and vocational services.
  - There is discretion to cover benefits assistants, case managers, and data exchanges.

(SAMHSA, 2019)

Staff Training

- Staff training on the benefits of MAT and addressing common misconceptions increases willingness to adopt; however, knowledge acquisition declines within 1 month.
- To change behavior, training must be combined with **organizational linkages, booster trainings, and opportunities for rehearsal of information.**
- Peer supervision or mentoring, and appointment of designated change agents (“champions”) advocate for continued organizational support.

(SAMHSA, 2019)

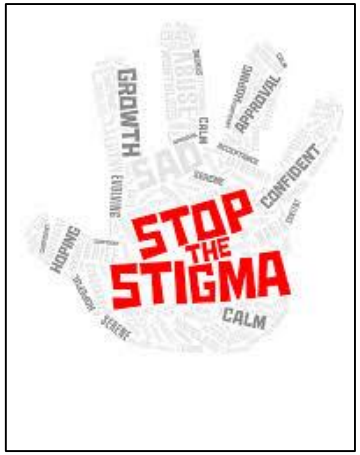
Staff Training (cont'd)

- MAT providers and criminal justice professionals meeting regularly for at least 12 months to discuss mutual concerns and resolve barriers increased actual referral intentions and rates (Friedmann et al, 2015).

- Equipping staff with naloxone kits, teaching them to assemble and use the applicators, and providing videotaped boosters increased actual uptake and distribution of naloxone kits (Anthony-North et al, 2018).

Addressing Stigma and Disapproval

- Use terms associated with greater empathy and optimism. (e.g., “recovery”, “recurrence of use”, “suffering from . . .”)
- Describe previously unsuccessful efforts at recovery without disheartened reactions (“devastated”).
- Use vignettes describing successful efforts at recovery.



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Addressing Stigma and Disapproval (cont'd)

- Describe practical misuse-prevention strategies.
- Educate about the disease model of addiction, including brain imaging & genetics.
- Describe common environmental and social precipitants (e.g., trauma, peer influences, poor prescription practices, exposure to advertising).
- Describe medical and psychiatric disorders that frequently co-occur with substance use disorders (e.g., chronic pain, depression, PTSD).

Staff Training re: Jail Sanctions

- Blanket prohibitions or routine denials of MAT violate the *Americans with Disabilities Act* (ADA), *Rehabilitation Act*, and possibly the 8th Amendment prohibition against "deliberate indifference" to medical needs of incarcerated people.
  - *Pesce v. Coppinger,* No. 18-11972-DJC (D. Mass. 2018); *Smith v. Aroostook County*, No. 1:18-cv-352-NT (D. Maine 2019), *aff'd* No. 19-1340 (1st Cir. 2019); *DiPierro v. Hurwitz*, No. 1:19-cv-10495-WGY (D. Mass.2019) (settlement agreement)
- At least one DOJ warning letter to a treatment court asserted that treating participants differently because they were receiving MAT violated the ADA.
- Sample letters to educate jail officials and others: https://lac.org

Addressing Obstacles to Medication-assisted Treatment in New York State Drug Courts

Steve Hanson

Associate Commissioner for Courts and Criminal Justice

New York State Office of Alcoholism and Substance Abuse Services

February 24, 2020

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Issues

There are several common obstacles to implementing Medication-assisted Treatment (MAT) in Drug Courts, including:

- Stigma
- Logistics/Access
- Cost
- Diversion concerns

Addressing Stigma

Stigma is the largest obstacle to MAT. The stigma is based on “philosophical” bias and erroneous beliefs about the medication (Wakeman and Rich, 2017).

Addressing Erroneous Beliefs

- Many people have achieved Recovery without medication.
  – **True**

- If you have to take a medication, it's not "real recovery."
  – **False**

- You are just replacing one drug with another.
  – **No, it's a medication.**

Addressing Erroneous Beliefs (cont'd)

- People on MAT are just zombies.
  – **False**

- People on MAT can't function normally.
  – **False**

- People on MAT can't take care of their children.
  – **False**

Addressing Erroneous Beliefs (cont'd)

- People standing in line for methadone look like they are still using drugs.
  - The people in line are generally those who have just started treatment. They haven't reached full stabilization yet.
  - As they continue in treatment, they look and feel better. They also don't have to stand in line every day.
  - You don't get to see the people who are doing well.

Changing Perspectives

- Historically, there have been many counselors in the field who are in recovery.
  - Their beliefs about MAT influence their treatment recommendations.
  - Many counselors would not recommend MAT as it conflicted with their beliefs.
  - As the opioid crisis has cost so many lives, and through education and research, MAT has become a recognized pathway for recovery for many.

Education to address erroneous beliefs

- The best way to address the mistaken beliefs is education (Westreich, 2019).
- Visit an opioid treatment program (OTP); talk with patients.
  - Access resources about evidence-based practices for MAT in criminal justice.
    - E.g., *Use of Medication-assisted Treatment for Opioid Use Disorder in Criminal Justice Settings.* SAMHSA, 2019.

Logistics/Access Planning

- Methadone for opioid use disorder (OUD) is highly regulated.
  - Methadone clinics are not available everywhere.
  - There are caps on the numbers of patients.
- Buprenorphine prescribing requires special certification.
  - Physicians might be deterred from offering.
  - There are caps on the number of patients.

(SAMHSA, 2012)

Evaluating Cost

Without insurance, the cost of medications can be great.

- Naltrexone (Vivitrol) - **$1176/month (est)**
- Buprenorphine - **$460/month (est)**
- Methadone - **$504/month (est)**

(National Institute on Drug Abuse, 2018)

Addressing Diversion Concerns

- Buprenorphine is commonly diverted.
- Some patients with low tolerance to buprenorphine may experience effects.
- Most patients receiving buprenorphine treatment remain on the medication to avoid withdrawal symptoms – exactly what it is prescribed for.
- Preventing diversion is difficult.

(Vocci et al, 2015; Lofwall and Walsh, 2014; Bentzley et al, 2015)

What's Really Important

- MAT saves lives.
- Studies have compared MAT vs. non-MAT treatment for opioid use disorder (OUD).
  - Non-MAT methods have been shown to have fatality rates as high as 20%.
  - MAT methods have 0% fatalities.

(Larochelle et al, 2018; Kakko et al, 2003)

Medications Help People Stay Alive

Helping people stay alive is our first and primary objective.

Addressing Stigma and Fostering Partnerships to Implement MAT

Shaun R. Floerke, JD
District Court Judge
6th Judicial District of Minnesota

February 24, 2020

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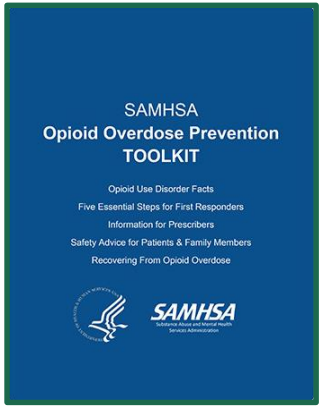
Data/Best Practices/Learning

- There is a need for data-driven best practices, and a move toward collecting data and evaluation.
  - MAT is a pressing, urgent, life-saving example.

Data/Best Practices/Learning (cont'd)



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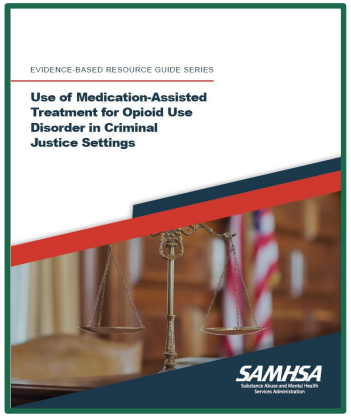

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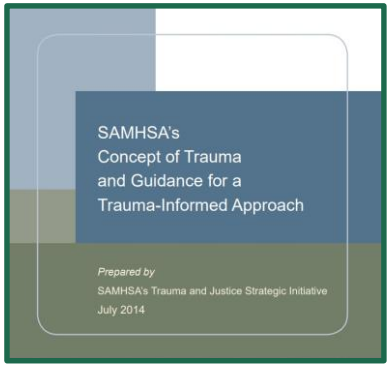

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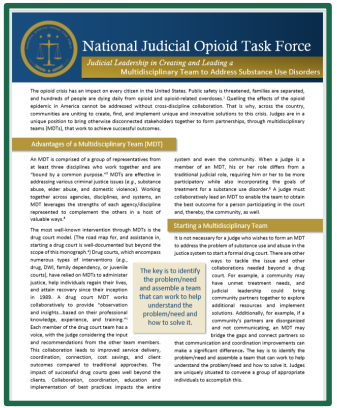

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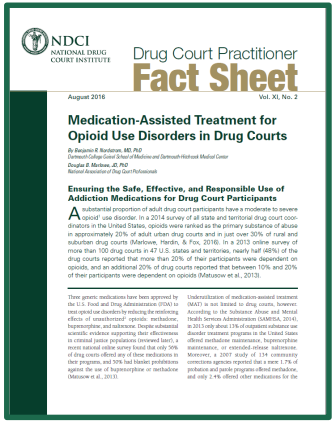

https://www.ndci.org/wp-content/uploads/2019/01/mat_fact_sheet-1.pdf

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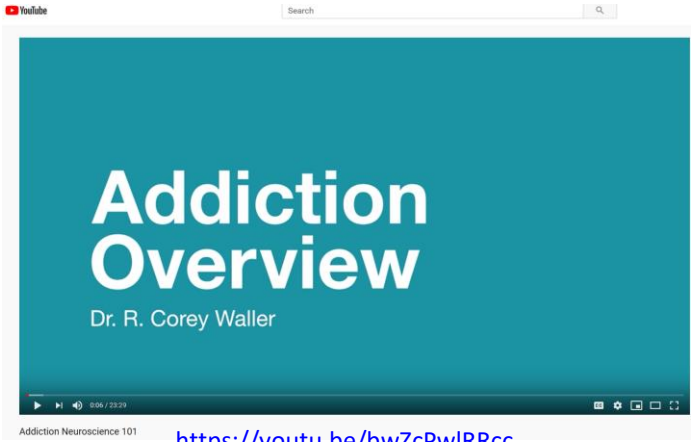
Getting the Judge on Board

- Change needs a champion and a team.
- Naloxone (Narcan) can be good start.
- Do we all need to be personally affected before we are willing to change our positions?
- Humanize, speak, share people's stories.

Train: Embrace the Research

- Addiction Neuroscience 101
- Many resources:
  - National Association of Drug Court Professionals (NADCP)
  - National Drug Court Institute (NDCI)
  - NPC Research (Northwest Professional Consortium, Inc.)
  - Online Resources



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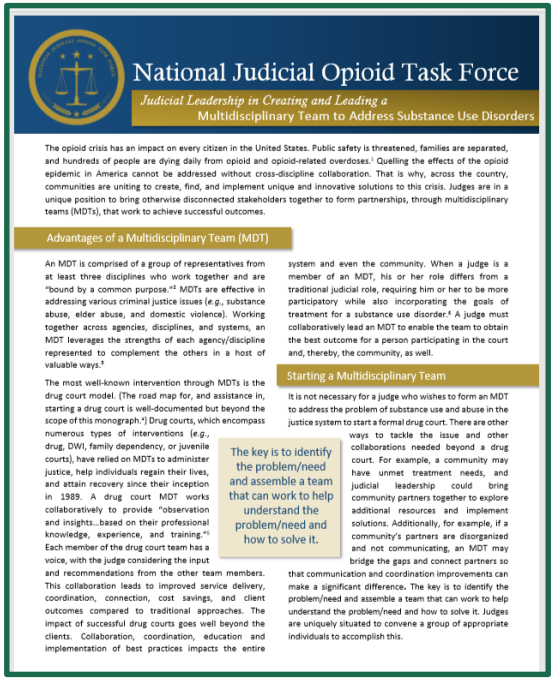
Hearts and Minds

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

- Margaret Mead

Resources for Download



National Judicial Opioid Task Force

Judicial Leadership in Creating and Leading a Multidisciplinary Team to Address Substance Use Disorders

The opioid crisis has an impact on every citizen in the United States. Public safety is threatened, families are separated, and hundreds of people are dying daily from opioid and opioid-related overdoses.[1] Quelling the effects of the opioid epidemic in America cannot be addressed without cross-discipline collaboration. That is why, across the country, communities are uniting to create, find, and implement unique and innovative solutions to this crisis. Judges are in a unique position to bring otherwise disconnected stakeholders together to form partnerships, through multidisciplinary teams (MDTs), that work to achieve successful outcomes.

Advantages of a Multidisciplinary Team (MDT)

An MDT is comprised of a group of representatives from at least three disciplines who work together and are "bound by a common purpose."[2] MDTs are effective in addressing various criminal justice issues (*e.g.*, substance abuse, elder abuse, and domestic violence). Working together across agencies, disciplines, and systems, an MDT leverages the strengths of each agency/discipline represented to complement the others in a host of valuable ways.[3]

The most well-known intervention through MDTs is the drug court model. (The road map for, and assistance in, starting a drug court is well-documented but beyond the scope of this monograph.[4]) Drug courts, which encompass numerous types of interventions (*e.g.*, drug, DWI, family dependency, or juvenile courts), have relied on MDTs to administer justice, help individuals regain their lives, and attain recovery since their inception in 1989. A drug court MDT works collaboratively to provide "observation and insights...based on their professional knowledge, experience, and training."[5] Each member of the drug court team has a voice, with the judge considering the input and recommendations from the other team members. This collaboration leads to improved service delivery, coordination, connection, cost savings, and client outcomes compared to traditional approaches. The impact of successful drug courts goes well beyond the clients. Collaboration, coordination, education and implementation of best practices impacts the entire system and even the community. When a judge is a member of an MDT, his or her role differs from a traditional judicial role, requiring him or her to be more participatory while also incorporating the goals of treatment for a substance use disorder.[6] A judge must collaboratively lead an MDT to enable the team to obtain the best outcome for a person participating in the court and, thereby, the community, as well.

Starting a Multidisciplinary Team

It is not necessary for a judge who wishes to form an MDT to address the problem of substance use and abuse in the justice system to start a formal drug court. There are other ways to tackle the issue and other collaborations needed beyond a drug court. For example, a community may have unmet treatment needs, and judicial leadership could bring community partners together to explore additional resources and implement solutions. Additionally, for example, if a community's partners are disorganized and not communicating, an MDT may bridge the gaps and connect partners so that communication and coordination improvements can make a significant difference. The key is to identify the problem/need and assemble a team that can work to help understand the problem/need and how to solve it. Judges are uniquely situated to convene a group of appropriate individuals to accomplish this.

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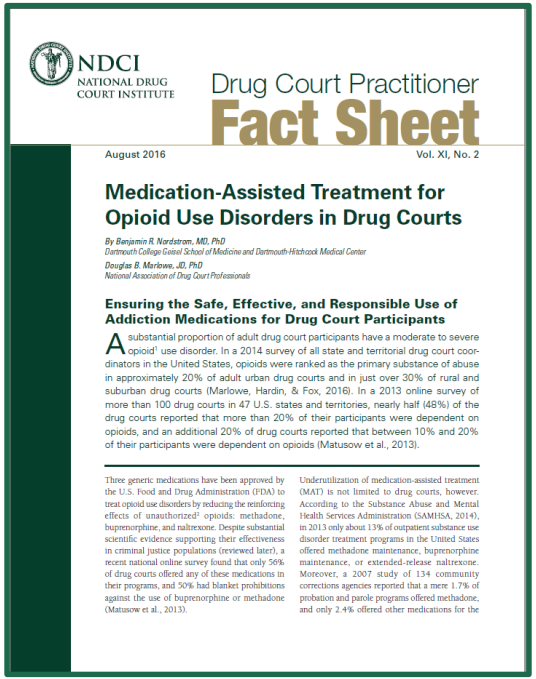

NDCI NATIONAL DRUG COURT INSTITUTE

Drug Court Practitioner **Fact Sheet**

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Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts

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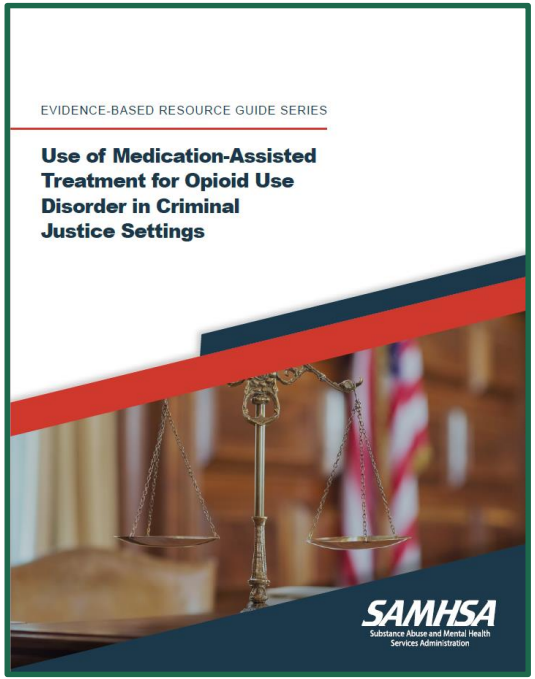
Dartmouth College Geisel School of Medicine and Dartmouth-Hitchcock Medical Center
Douglas B. Marlowe, JD, PhD
National Association of Drug Court Professionals

Ensuring the Safe, Effective, and Responsible Use of Addiction Medications for Drug Court Participants

A substantial proportion of adult drug court participants have a moderate to severe opioid[1] use disorder. In a 2014 survey of all state and territorial drug court coordinators in the United States, opioids were ranked as the primary substance of abuse in approximately 20% of adult urban drug courts and in just over 30% of rural and suburban drug courts (Marlowe, Hardin, & Fox, 2016). In a 2013 online survey of more than 100 drug courts in 47 U.S. states and territories, nearly half (48%) of the drug courts reported that more than 20% of their participants were dependent on opioids, and an additional 20% of drug courts reported that between 10% and 20% of their participants were dependent on opioids (Matusow et al., 2013).

Three generic medications have been approved by the U.S. Food and Drug Administration (FDA) to treat opioid use disorders by reducing the reinforcing effects of unauthorized[2] opioids: methadone, buprenorphine, and naltrexone. Despite substantial scientific evidence supporting their effectiveness in criminal justice populations (reviewed later), a recent national online survey found that only 56% of drug courts offered any of these medications in their programs, and 50% had blanket prohibitions against the use of buprenorphine or methadone (Matusow et al., 2013).

Underutilization of medication-assisted treatment (MAT) is not limited to drug courts, however. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), in 2013 only about 13% of outpatient substance use disorder treatment programs in the United States offered methadone maintenance, buprenorphine maintenance, or extended-release naltrexone. Moreover, a 2007 study of 134 community corrections agencies reported that a mere 1.7% of probation and parole programs offered methadone, and only 2.4% offered other medications for the



EVIDENCE-BASED RESOURCE GUIDE SERIES

Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings

SAMHSA
Substance Abuse and Mental Health Services Administration

SAMHSA
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Thank You

Substance Abuse and Mental Health Services Administration

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)

GAINS Center for Behavioral Health and Justice Transformation

The GAINS Center focuses on expanding access to services for people with mental and/or substance use disorders who come into contact with the justice system.

https://www.samhsa.gov/gains-center

1-800-311-4246

SAMHSA
Substance Abuse and Mental Health Services Administration