



Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts

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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 opioid¹ 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 unauthorized² 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



treatment of substance use disorders (Chandler, Fletcher, & Volkow, 2009). Substantial efforts are needed to educate drug court professionals and other criminal justice and treatment professionals about the potential benefits of and medical indications for MAT.

Opioid Use Disorders

Opioids stimulate nerve receptors in the brain that are part of a natural reward system (Borg et al., 2014; Kosten & George, 2002). When humans or animals engage in behaviors that are beneficial to survival, such as eating or mating, the reward system releases natural chemicals called *endorphins*. Endorphins produce a pleasurable response and encourage the individual to repeat the beneficial behavior. Without this critically important reward system, humans and animals would be at risk of serious illness or death. Endorphins also provide other important benefits for survival, such as reducing pain (Gallagher, Koob, & Popescu, 2014).

Exogenous opioids (those not produced naturally in the body) are structurally similar to endorphins and fit into the same receptors in the brain (Borg et al., 2014; Kreek, 2008). Often they will stimulate those receptors with far greater intensity than the brain is accustomed to experiencing. The resulting sensations are immediate, reliable, and can be extremely pleasurable, and they will often incite the individual to take the drug repeatedly (Park & Friedmann, 2014). Over time, the receptors become accustomed to the stimulation and reduce their sensitivity accordingly. This process leads to *tolerance*, which requires the individual to take larger and larger doses to achieve the desired effect (Kosten & George, 2002). As the brain becomes accustomed to the drug, it may also lessen production or release of its own endorphins (Kreek, 2008). As a result, the individual may become less able to experience basic pleasure from naturally rewarding activities, such as eating or socializing with others (Kosten & George, 2002).

Repeated exposure to opioids may also disrupt other brain regions. An area called the *locus coeruleus* may overproduce a chemical called *noradrenaline* (or *norepinephrine*), leading to extremely uncomfortable withdrawal symptoms (e.g., severe bone pain, chills, sweating, nausea, vomiting, anxiety, muscle cramps, diarrhea) when levels of the drug decline in the body (Kosten & George, 2002; Kreek, 2008). Disruptions in other brain regions, including the amygdala and nucleus accumbens, have also been implicated in causing withdrawal symptoms (Koob, 2008).

Opioids can further interfere with the functioning of the frontal lobe of the brain, which is responsible for judgment, planning, and insight. As a result, the individual may be more inclined to act impulsively, fail to consider the consequences of his or her actions, and neglect the persistent negative repercussions of drug use (Baler & Volkow, 2006; Chandler et al., 2009; Dackis & O'Brien, 2005; Goldstein et al., 2009). As all of these adaptive changes accumulate in the brain, the net result is what is familiarly known as the *addiction syndrome*—compulsive drug seeking, reduced involvement in productive activities, impaired insight, and persistently self-destructive behaviors (Volkow & Warren, 2014).

MAT for Opioid Use Disorders

Successful treatment of opioid use disorders typically requires a combination of medication, behavioral or cognitive-behavioral counseling, and other indicated psychosocial services, such as vocational or educational training (Center for Substance Abuse Treatment [CSAT], 2004, 2005). Studies indicate that outcomes are significantly better when psychosocial counseling is delivered in conjunction with MAT; however, information is lacking on which specific psychosocial treatments produce the best effects (Dugosh et al., 2016). The term *medication-assisted treatment* draws attention to the proper role of medication as *assisting* other forms

Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts

of treatment to succeed (McLellan, 2008). A drug court that refers participants for MAT without also monitoring them closely and ensuring that indicated psychosocial services are delivered is out of compliance with best practice standards for the field (National Association of Drug Court Professionals [NADCP], 2013, 2015).

MAT for opioid use disorders seeks to interrupt the addiction process by chemically occupying relevant receptors in the brain, thus blocking or reducing the effects of unauthorized opioids (Stine & Kosten, 2014). Three types of medications are commonly prescribed for the treatment of opioid use disorders: agonists such as methadone, antagonists such as naltrexone, and partial agonists such as buprenorphine.

Opioid Agonists

Opioid agonist medications such as methadone belong to the same pharmacological category as illicit opioids (Borg et al., 2014; Schottenfeld, 2008). They mimic the effects of endorphins on the brain by binding to and activating opioid receptors, thus competing against unauthorized opioids to occupy those same receptors (Kreek, 2008; Schottenfeld, 2008; Stine & Kosten, 2014). Because they work in much the same way as illicit opioids, they can produce many of the same psychoactive effects in nontolerant individuals, including euphoria and withdrawal (Borg et al., 2014). They are also addictive and can cause serious side effects, including respiratory suppression, which may lead to overdose and death (Schottenfeld, 2008).

Agonist medications are, however, considerably longer acting than illicit opioids, produce significantly less intoxication and sedation, and elicit rapid tolerance to the medication's physiological effects (Martin, Zweben, & Payte, 2014). When the medication is administered properly in a gradually escalating dosage, patients do not become intoxicated or euphoric and do not experience cravings or withdrawal (Schottenfeld, 2008; Stine & Kosten, 2014). Properly treated patients should be capable of engaging in most daily activities, including nonhazardous employment, school, or child care, without experiencing debilitating symptoms or cognitive impairment. Most important, if patients receive a sufficient dosage of an agonist medication,

they should not experience cravings for opioids or become intoxicated by ingesting unauthorized opioids (Martin et al., 2014). They may, however, become intoxicated by ingesting other types of drugs, such as alcohol, marijuana, or cocaine. This possibility requires drug courts to monitor participants carefully for use of a wide range of substances to ensure that they do not substitute new substances for opioids (Heikman, Sundström, Pelander, & Ojanperä, 2016).

Opioid Antagonists

Opioid antagonist medications such as naltrexone do not belong to the same pharmacological category as opioids (O'Brien & Cornish, 2006). Antagonists bind with many of the same receptor sites in the brain as opioids, but they do not stimulate those receptors (O'Brien & Kampman, 2008). Instead, antagonists sit inertly on the receptors and prevent opioids from getting through. Because antagonists do not stimulate opioid receptors they do not cause euphoria or intoxication (Stine & Kosten, 2014). They also do not cause many of the deleterious side effects associated with agonist medications, such as respiratory suppression. A cause for concern, however, is that patients may be at risk for overdose if they resume unauthorized opioid use once antagonists are discontinued. This is because tolerance declines during antagonist treatment, and a sudden return to previous levels of opioid use can have serious medical consequences (RxList, 2013; SAMHSA, 2012).

One drawback to naltrexone is that patients must first be detoxified fully from opioids (followed by 7 to 10 days of continuous abstinence) before taking the medication (O'Brien & Kampman, 2008; SAMHSA, 2012). Administration of naltrexone prior to detoxification will precipitate an acute and severe withdrawal. For this reason, naltrexone may not be feasible for participants with severe opioid use disorders who cannot achieve an abstinent state. Although detoxification can often be accomplished in a residential setting for patients with severe opioid use disorders, not all drug courts have access to residential or detoxification treatment. Naltrexone can also cause withdrawal from opioid medications that are prescribed lawfully to treat pain or other medical conditions. Therefore, naltrexone is not a suitable treatment option



for participants who are receiving approved opioid prescriptions (O'Brien & Kampman, 2008).

Naltrexone is available generically in oral form (e.g., ReVia or Depade) and in a long-acting injectable form called Vivitrol. Vivitrol is administered via intramuscular injection, typically in the buttocks, and the effects last for approximately 30 days. Because the majority of patients in voluntary outpatient treatment stop taking oral naltrexone prematurely, a major contribution of Vivitrol is its ability to increase medication compliance substantially (O'Brien & Cornish, 2006).

Partial Opioid Agonists

Some medications, such as buprenorphine, are referred to as *partial agonists* or *mixed agonists/antagonists* because they partially stimulate opioid receptors and also produce some blockade effects (Stine & Kosten, 2014; Strain & Lofwall, 2008). As a result, partial agonists produce a lower ceiling of effects than full agonists such as heroin or methadone (Cowan, 2007). Partial agonists can treat withdrawal symptoms and cravings but are less likely to cause intoxication or dangerous side effects such as respiratory suppression.

Buprenorphine is marketed currently under the brand names Subutex, Suboxone, Zubsolv, and Bunavail. The medication is typically absorbed gradually under the patient's tongue (sublingually) or attached to the inner cheek. Buprenorphine may be combined with another medication, naloxone, which is pharmacologically similar to naltrexone. If a patient tries to inject or crush the medication in an effort to experience a stronger intoxicating effect, the naloxone will be released and precipitate withdrawal (Strain & Lofwall, 2008). As a result, this combination can substantially reduce the likelihood of inappropriate usage. However, buprenorphine alone without naloxone is recommended for use during detoxification to avoid causing withdrawal (Strain & Lofwall, 2008) and to treat pregnant women (Jones et al., 2012).

One potential advantage of buprenorphine over methadone is that buprenorphine may be prescribed outside of a federally regulated opioid treatment program (21 C.F.R. §§ 1301.28, 1306.07[d]). This practice is commonly referred to as *office-based opioid treatment*, or OBOT, and is intended to make the medication more readily available to patients in need (Arfken, Johanson, di Menza, & Schuster, 2010).

Effectiveness of MAT

Most studies of MAT in the criminal justice system have focused on individuals on probation or parole. No study has examined the effectiveness of MAT for treating opioid use disorders in drug courts; however, preliminary evidence suggests that extended-release naltrexone can reduce alcohol use among drug court participants (Finigan, Perkins, Zold-Kilbourn, Parks, & Stringer, 2011).

Use of all three medications is associated with significantly reduced use of unauthorized opioids among probationers, parolees, and other persons with opioid use disorders involved in the criminal justice system (Clark, Hendricks, Lane, Trent, & Cropsey, 2014; Cornish et al., 1997; Crits-Christoph, Lundy, Stringer, Gallop, & Gastfriend, 2015; Cropsey et al., 2011; Gordon, Kinlock, Schwartz, & O'Grady, 2008; Gryczynski et al., 2012; Kinlock, Gordon, Schwartz, Fitzgerald, & O'Grady, 2009; Lee et al., 2016; Mitchell et al., 2014). Most studies have compared the effects of the medications combined with psychosocial counseling to counseling alone without MAT. Results of randomized, controlled studies revealed that MAT combined with counseling reduced unauthorized opioid use significantly better than counseling alone (Cornish et al., 1997; Gordon et al., 2008; Kinlock et al., 2009; Lee et al., 2016).

Methadone and buprenorphine have also been found to significantly increase treatment entry and retention among individuals on probation and parole (Gordon et al., 2008; Gordon et al., 2014; Kinlock et

Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts

al., 2009; Magura et al., 2009). Although some studies have reported significantly reduced rearrest rates, reincarceration rates, or self-reported criminal activity for probationers or parolees receiving methadone or buprenorphine (Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012), the effects on crime outcomes have not been consistent (Egli, Pina, Skovbo Christensen, Aebi, & Killias, 2011; Magura et al., 2009; Miller, Griffin, & Gardner, 2016; Perry et al., 2015). Naltrexone, in contrast, has been consistently demonstrated to reduce rearrest and reincarceration rates (Cornish et al., 1997; Egli et al., 2011; Perry et al., 2015), and the extended-release formulation of naltrexone has been found to increase treatment retention in criminal justice populations (Crits-Christoph et al., 2015).

At present, no basis exists for concluding that any one medication is superior to another in reducing unauthorized opioid use (Perry et al., 2015). Two studies conducted in the criminal justice system found no differences in outcomes between methadone and naltrexone (Lobmaier, Kunøe, Gossop, Katevoll, & Waal, 2010) or between methadone and buprenorphine (Magura et al., 2009). Most studies conducted outside of the criminal justice system have similarly found that methadone and buprenorphine were equivalently effective at reducing unauthorized opioid use (Mattick, Breen, Kimber, & Davoli, 2014; Petitjean et al., 2001; Soyka, Zingg, Koller, & Kuefner, 2008).

Best Practice Standards for MAT in Drug Courts

Best practice standards require drug courts to permit the use of MAT in appropriate cases. In 2011, the NADCP board of directors issued a unanimous resolution directing drug courts to undertake the following:

- Keep an open mind and learn the facts about MAT.
- Obtain expert medical consultation on MAT when available.
- Make a fact-sensitive inquiry in each case to determine whether MAT is medically indicated or medically necessary for the participant.
- Explain the court's rationale for permitting or disallowing the use of MAT.

The resolution also states explicitly that drug courts should not have blanket prohibitions against MAT (NADCP, 2011).

In 2013, NADCP released Volume I of the *Adult Drug Court Best Practice Standards*. Standard I (Target Population) provides that candidates for drug courts should not be excluded from participation in the program because they have a legally valid prescription for an addiction or psychiatric medication (NADCP, 2013). Standard V (Substance Abuse Treatment) further directs drug courts to offer MAT when it is prescribed and monitored by a physician trained in addiction psychiatry, addiction medicine, or a related medical field. Finally, Standard VI (Complementary Treatment and Social Services), released in Volume II of the *Standards*, directs drug courts to offer psychiatric medications for co-occurring mental health disorders when prescribed and monitored by a psychiatrist or other duly trained medical practitioner (NADCP, 2015).

Drug courts that ignore these provisions are operating below the recognized standard of care for the profession. These drug courts expose themselves to serious criticism, may find themselves ineligible for certain drug court funds, and may be overruled on appeal.

Legal Standards for MAT in Drug Courts

Best practice standards are derived from scientific evidence indicating which policies and practices are associated with better outcomes in drug courts. Legal standards, in contrast, are derived from constitutional or other legal principles governing what actions may be taken in a court of law. Legal standards relating to MAT will vary depending on whether a drug court is receiving federal funding and whether contrary medical evidence has been offered to challenge the propriety of a prescription.

Beginning in 2015, drug courts receiving federal funding pursuant to the Adult Drug Court Discretionary Grant Program must attest in writing that they will not deny otherwise eligible candidates access to the program because of a candidate's use of an FDA-approved medication for the treatment of a substance use disorder, and they will not require participants to discontinue such medications as a condition of graduating from the program (U.S. Department of Justice, 2015). The grant language creates a difficult-to-rebut presumption that MAT will be permitted if it is prescribed lawfully by a licensed medical practitioner



who has personally examined the participant, diagnosed him or her as having a substance use disorder, and determined that the medication is appropriate to treat the disorder. Drug courts may overrule such determinations only if the court finds that a participant has been misusing or abusing the medication or diverting the medication for unauthorized purposes.

The MAT attestation applies only to drug courts receiving Bureau of Justice Assistance or SAMHSA funding; however, it may offer an apt analysis for any drug court dealing with an uncontested prescription for MAT. Although judges have wide discretion to impose conditions of probation or community supervision, that discretion is not unbridled. The conditions cannot be arbitrary and must be reasonably related to the goals of protecting public safety or rehabilitating the individual (*Roberts v. U.S.*, 1943). If there is no opposing medical evidence to suggest that a prescription may be unnecessary or contraindicated, and if there is no indication that the participant has been misusing or diverting the medication, then rarely will there be a reasonable basis for a drug court to deny a lawful prescription for MAT from a qualified physician who has diagnosed the participant and will continue to manage the case medically going forward.

A more difficult challenge may arise if a drug court is not receiving federal funding and contrary medical evidence is offered to suggest a prescription may not be medically necessary or indicated. If, for example, the prosecution wishes to offer its own medical evidence to show that a prescription is unnecessary or contraindicated, the judge will need to rule on the matter after considering medical evidence from both sides. In this relatively circumscribed set of cases, medical experts will be required to provide the drug court with a convincing rationale for using or not using MAT in light of the specific facts of the case.

Some physicians may be unaccustomed to having their medical decisions questioned by laypersons,

and even experienced physicians can have a difficult time explaining their decision-making process to nonmedical professionals. Some physicians may misinterpret well-intended questions about the basis for their opinions as an indication that drug courts are against MAT or that judges are practicing medicine without a license. This inference is not justified. A judge who questions the rationale for a medical expert's opinion in a contested case is striving to make an informed and reasoned decision in light of conflicting medical evidence. A medical expert who refuses or is unable to answer such questions does a disservice to his or her patient and to the administration of justice.

Blanket Prohibitions

Under no circumstance should a drug court have a blanket prohibition against MAT as a matter of policy. As discussed previously, NADCP's *Best Practice Standards* (2013, 2015) and the resolution of its board of directors on MAT (2011) require drug courts to evaluate requests for MAT on a case-by-case basis.

Blanket prohibitions against MAT may also be held unconstitutional and could be reversed on appeal. Some commentators have asserted that drug court participants may have a fundamental constitutional right, or a statutory right under the Americans with Disabilities Act, to receive MAT (Legal Action Center, 2009). If this assertion is correct, then drug courts would require a compelling state interest or a substantial reason to deny MAT. The court's ruling would also need to be narrowly tailored to achieve legitimate government aims (see, e.g., *People v. Hackler*, 1993). If the court could impose conditions on the use of MAT that would adequately protect public safety and prevent misuse of the medication, such as requiring observed administration of the medication, then a complete prohibition would not be narrowly tailored.

As of this writing, no published court opinion has considered whether persons under community

Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts

criminal justice supervision have a fundamental or statutory right to receive MAT. If such a right is not found to exist, then the governing constitutional standard would be a rational basis test (Petersilia, 1998; *Roberts v. U.S.*, 1943). Under the rational basis test, conditions may not be unduly broad or arbitrary and must be reasonably related to the person's crime, likelihood of rehabilitation, or risk of future criminality (see, e.g., *Commonwealth v. Hartman*, 2006; *People v. Beaty*, 2010; *People v. Lent*, 1975; *State v. Philipps*, 1993). Judges are also required to impose individualized or particularized conditions (*Commonwealth v. Wilson*, 2010; *In re. Victor L.*, 2010; *U.S. v. Carter*, 2009). Every participant has a right to introduce relevant evidence specific to his or her case. It is fundamentally unfair for a judge to make a factual determination in one case and to assume, conclusively, that the same facts apply in other cases.³

These constitutional standards require drug court judges to (1) consider relevant information before making a factual determination, (2) hear arguments from both sides of the controversy (the defense and prosecution), and (3) receive information from scientific experts if the subject matter of the controversy is beyond the common knowledge of laypersons (Hora & Stalcup, 2008; Meyer, 2011). Medical evidence is typically beyond the knowledge of laypersons; therefore, in most cases it should be introduced or explained by a qualified medical expert. This information may be provided during team discussions in precourt staff meetings or through courtroom testimony.

A drug court that has a blanket prohibition against MAT (or against a particular medication such as methadone or buprenorphine) is, in effect, prejudging a factual matter before hearing evidence from both sides of the dispute and considering the particular facts of each case. Refusing to consider relevant evidence before making a factual determination may be viewed by an appellate court as an abuse of discretion. Trial courts are required to provide a rationale for such decisions, based on the particularized facts of the case, which is sufficient to permit meaningful appellate review (see, e.g., *U.S. v. Carter*, 2009). In the absence of an adequate record, appellate courts may overrule such baseless decisions and return the matter to the lower court for reconsideration.

Contested Matters

If a drug court is not subject to the federal funding attestation and contrary medical evidence has been offered to challenge a prescription for MAT, then the court may be called upon to resolve the conflicting arguments. In this limited class of cases, the court is not substituting its judgment for that of trained medical experts but rather is weighing the relative bases for conflicting medical opinions. Evaluating the credibility of expert evidence is an appropriate function of a court of law. This process requires medical experts to provide the court with a credible rationale for allowing or disallowing the use of a medication in a given case. Physicians are often called upon to explain their medical recommendations to patients, patients' family members, and third-party payers, and they may also be called upon to do so for judges and other criminal justice professionals who are responsible for rehabilitating persons charged with serious crimes, protecting public safety, and ensuring the fair and orderly administration of justice.

An unanswered question is what substantive legal standard applies to these matters in drug courts. The standards of *medical necessity* and *medical indication* have been applied most commonly in other legal contexts involving contested medical procedures, such as interpreting covered services in insurance policies, and these standards might be applied by analogy to drug court proceedings.

Medical necessity calls for more stringent evidence than medical indication, and requires or permits the court to take a wider range of factors into consideration (Garber, 2001). In the insurance context, for example, medically necessary treatment has been interpreted to mean treatment that meets the following criteria (see, e.g., *Hawaii Medical Service Association v. Adams*, 2009):

- Generally accepted by the medical community for treating the disorder in question
- Provided at the most appropriate level and intensity of care
- Takes into consideration the risks and benefits of that treatment, as well as alternative treatments that may be available to treat the same condition
- Proven to be effective for improving health outcomes



By analogy, if a drug court participant seeks permission to receive buprenorphine, under a standard of medical necessity the drug court judge would be required or permitted to consider, among other factors, the relative risks and benefits of buprenorphine for the participant as compared to other indicated treatments for opioid use disorders, such as methadone, naltrexone, or drug-free counseling.

In contrast, medical indication is a lighter standard to meet than medical necessity and may include elective, optional, or experimental treatments (Garber, 2001; *Hawaii Medical Service Association v. Adams*, 2009). Several treatments may be medically indicated for the same disorder, and the drug court judge would not be called upon to balance the relative risks and benefits of alternative treatments.

In the absence of legal precedent to guide these decisions, drug courts should indicate what standard they are applying and describe on the record the bases for their conclusions concerning MAT in contested cases. Failing to articulate a coherent rationale for a decision increases the likelihood that the decision will be overruled on appeal or the matter returned to the drug court to develop a factual record. This recommendation does not suggest that drug courts must always hold a full evidentiary hearing and develop a transcript of the proceedings to resolve contested matters relating to MAT. It may be possible in many instances to consider arguments from all interested parties, articulate a rational decision concerning MAT, and preserve the matter for appeal during the course of a routine drug court entry hearing or status hearing.

Minimizing Misuse and Diversion

Regardless of whether a drug court is receiving federal funding or a prescription for MAT has been contested, all drug courts have an obligation to minimize the chances that medications will be misused by participants or diverted for illegal purposes. Drug courts should order additional monitoring requirements or other conditions, as

necessary, to ensure that medications are taken as prescribed and do not pose a risk to public safety or undermine the integrity and reputation of the criminal justice system. Several practical precautions can be taken by drug courts to reduce or eliminate the risk of misuse or diversion of prescription medications, and studies have confirmed that several of these measures can significantly reduce untoward events related to MAT (Wright et al., 2015).

- *Observed administration.* One of the most effective ways to prevent misuse or diversion of prescription medication is to require that the medication be ingested under the direct observation of treatment or court staff. If a physician's office is ill equipped for observed ingestion, then medication ingestion may be observed by a probation officer, clinical case manager, or other approved individual such as a trusted, sober, and prosocial family member or friend of the participant.
- *Adherence monitoring.* The presence of prescribed medications or their metabolites may be monitored through urine or other appropriate testing methods on a random basis to confirm that the medication is being taken reliably (CSAT, 2005). If a test does not reveal the presence of a prescribed medication or its metabolites at an anticipated level, this may suggest the medication is being overused, underused, or possibly diverted. Some methods involve analysis of blood or plasma samples (Chan & Harun, 2016; Chawarski, Schottenfeld, O'Connor, & Pakes, 1999); therefore, this level of intrusion may be justified only in cases involving suspected repeated infractions related to MAT.
- *Random callbacks.* Participants may be called back to the treatment program or drug court on a random basis for pill counts to confirm that the medication is being taken as prescribed. A short pill count may indicate the medication is being taken too often or in excessive doses or is being sold or traded illegally. A high pill count indicates the medication is not being taken as prescribed.
- *Medication event monitoring system.* A medication event monitoring system (MEMS) is a medication

Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts

container or cap with a microprocessor that records the date, time, and number of pills that were removed each time the container is opened. Use of a MEMS provides a reliable indicator of medication compliance among individuals with severe mental health disorders (Remington et al., 2007); however, it has not been evaluated in a criminal justice population.

- *Preapprovals.* Except in medical emergencies, participants should be required to receive preapproval from the drug court before obtaining a new prescription for an addictive or intoxicating medication. The participant should be required to inform the treating physician that he or she has a substance use disorder diagnosis and is participating in a drug court. The participant should also be required to sign any requisite releases of information that are necessary for the physician to communicate freely with the drug court team about the participant's diagnosis, prognosis, treatment plan, and course of treatment.
- *Prescription drug monitoring programs.* Forty-nine states and the Territory of Guam participate in prescription drug monitoring programs (PDMPs). PDMPs are state-maintained electronic databases containing information on all controlled substances prescribed within the state and other states with reporting reciprocity (Centers for Disease Control and Prevention, 2015). Reports typically include a list of all prescriptions for controlled substances filled for a given individual within the previous 12 months. Studies indicate that implementation of PDMPs has been associated with significant reductions in opioid-related overdose deaths and unwarranted opioid prescriptions in the U.S. (Chang et al., 2016; Delcher, Wagenaar, Goldberger, Cook, & Maldonado-Molina, 2015; Patrick, Fry, Jones, & Buntin, 2016). Where permitted by law, drug courts are encouraged to obtain PDMP reports on all of their participants, not just those receiving authorized prescriptions, as a check on unauthorized medication use.
- *Abuse-deterrence formulations.* Abuse-deterrence formulations are available for several addiction medications. For example, misuse and diversion of medications has been reduced significantly by combining naloxone with buprenorphine, administering the long-acting injectable formulation of naltrexone, administering methadone in liquid form, and administering buprenorphine in the form of a soluble sublingual tape (Wright et al., 2015).

Failure to abide by these conditions may be viewed as a willful infraction of the rules of the program and sanctioned accordingly. For example, if a participant's urine test does not reveal the presence of a prescribed medication or its metabolites at an anticipated level, if a pill count falls short of the expected number of pills, or if a participant obtains an unauthorized prescription for an addictive or intoxicating medication, this fact may be taken as evidence of illicit diversion, unauthorized drug use, or a failure to obey critical program requirements. The participant handbook should spell out clearly participants' responsibilities with regard to prescription medications and the potential consequences of failure to meet these important obligations (NADCP, 2013, 2015).

Locating Qualified Medical Providers

Many drug courts rely on their treatment team members or local substance use disorder treatment programs to determine whether MAT is indicated and to identify qualified medical practitioners. Unfortunately, many treatment programs do not have physicians or nurses on staff (McLellan, Carise, & Kleber, 2003; National Center on Addiction and Substance Abuse, 2012) and some treatment agencies working with drug courts may have limited access to or familiarity with medical treatments (Matusow et al., 2013). Drug courts may find it necessary to look beyond their immediate team members to identify qualified medical providers.

The websites listed on the next page provide directories of physicians or treatment agencies specializing in addiction medicine or addiction psychiatry. Most of these websites can be queried by city, state, or zip code to identify medical practitioners located close to a drug court.

In addition, local single-state agencies for substance use disorder treatment usually maintain lists of credentialed providers, including those authorized to provide private office-based treatment with buprenorphine. Colleges, universities, and medical schools are also excellent resources for locating substance use disorder specialists; however, qualified faculty members are likely to already be included on at least one of the directories listed on page 10. Finally, drug courts are encouraged to contact their



Provider Resources

- **American Academy of Addiction Psychiatry**
www.aaap.org/patient-resources/find-a-specialist
- **American Board of Addiction Medicine**
www.abam.net/find-a-doctor
- **American Society of Addiction Medicine**
community.asam.org/search
- **SAMHSA Behavioral Health Treatment Services Locator**
findtreatment.samhsa.gov
- **SAMHSA Buprenorphine Treatment Physician Locator**
www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

state or county board of health to identify medical practitioners offering substance use disorder treatment in their area.

Conclusion

It is not possible for drug court professionals or addiction physicians to perform their jobs effectively without improving interdisciplinary communication. Drug courts cannot deliver effective treatment without medical input, and physicians cannot hope to reach large numbers of individuals suffering from substance use disorders without learning to function in a criminal justice environment.

Although both professions may at times need reminding, learning to work collaboratively is a core responsibility of each discipline. The courtroom forum is designed specifically to examine unproven assumptions and discover truth. Due process requires a fair hearing on factual matters and forces all parties to prove the logic and accuracy of their assertions. It is not acceptable for drug courts to have blanket prohibitions against MAT or to act on

the basis of incomplete or erroneous information when making fundamental decisions that affect participants' health and welfare. Failing to consider scientific evidence when making decisions about MAT falls short of best practice standards (NADCP, 2013, 2015) and may under some circumstances amount to an abuse of judicial discretion.

Medical experts, for their part, must learn to communicate effectively with criminal justice professionals. Some individuals suffering from opiate use disorders will need MAT for a period of time, others may need it indefinitely, and still others may not need it at all (Stine & Kosten, 2014). For those who do need MAT, some will be well suited to treatment with an antagonist medication and others will require an agonist or partial-agonist medication. It is the role of a competent physician to determine, based on the best available information, what regimen is most likely to be successful for a given patient. It is also the responsibility of a physician to explain this decision-making process to nonmedical persons, including the patient, the patient's loved ones, and third-party payers. Asking physicians to do the same for criminal justice professionals is consistent with their professional duties and an unavoidable requirement of the law.

Physicians are likely to find that the quality of their medical practice improves significantly when they are asked to articulate their decision-making process to nonmedical professionals. Giving words to one's actions and describing one's thought processes to interested third parties has a way of sharpening clinical skills and enhancing treatment results. Drug court teams, in turn, will find they learn a great deal about the neuroscience of substance use disorders if they open their minds, ask the right questions, and listen impartially to the answers (Matejkowski, Dugosh, Clements, & Festinger, 2015). The development of collaborative working relationships between physicians and drug court professionals is likely to raise the bar for both disciplines and optimize outcomes for drug court participants, the judicial system, and the public at large.

Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts

Endnotes

1. The term *opiate* commonly refers to drugs that are extracted from the poppy plant, whereas *opioid* refers to drugs that are synthesized in a laboratory to produce the same psychoactive or medicinal effects as opiates. Unless otherwise indicated, the term *opioid* is used in this document to refer to both opiates and opioids.
2. Unauthorized opioids include illicit opiates such as heroin and pharmaceutical opioids such as oxycodone that are taken for a nonmedical purpose, without a lawful prescription, or without prior approval from the drug court and not during a medical emergency.
3. An exception is when courts take judicial notice of facts that are so well established there is no need to relitigate the issue. For example, a court might take judicial notice of the fact that buprenorphine is approved by the FDA for the treatment of opioid dependence. Courts have not taken judicial notice of facts that would justify a blanket prohibition against MAT.

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