Justice Speakers Institute

SPEAKING, TEACHING & TRAINING - WORLDWIDE

Using Medication Assisted Treatment in Drug Treatment Court

Hon. Peggy Fulton Hora

President, Justice Speakers Institute

13th Annual Tennessee Recovery Drug Court Conference

Dec. 7, 2017

Sponsored by: Drug Testing Program Management

A Little History

- Taking methadone is trading one addiction for another. T or F?

- NADCP Conference in 2003 answered “true” by over 50%!

New England Association of Drug Court Professionals, member of the Board of Directors, said, “I’m a judge and I don’t believe in Methadone.”

Methadone is a medication, not a belief system!

Drug Treatment Courts (DTCs)

- Developed over 25 years ago to address the "war on drugs" incarceration rates
- Recognition that treatment was the most effective solution to crime and public safety

Abstinence Based

- DTCs are abstinence-based programs
- Most courts include a prohibition on alcohol
- Some prohibit tobacco
- Some prohibit “medical” marijuana
- Many judges do not allow graduation or disallow participation if the defendant is on Medically Assisted Treatment (MAT)

A True Story

- In 2000, Bradley Douglas Moore, an addict with a 12-year heroin habit, had the "best summer of his life" according to his wife, when he started a Methadone program.
- He was given 45 days to get off Methadone as a condition of participation in the Nevada County (CA) drug treatment court.

A True Story, cont.

- As his dose dropped, he began to get sick so he started using heroin again. He "kicked cold turkey" in jail and though clean when released, he was "angry and on edge" according to his wife. He said, "If this is what sobriety is like, I'd rather be a junkie."
- He died of a heroin overdose one week later

A True Story, cont.

- His judge said, "…[I]f a person chooses to not be a drug addict, they can also choose to not be addicted to methadone. Our goal is to break the cycle of addiction."
- The judge admitted he never had any input from a medical professional.

A True Story, cont.

- His health care professionals said, “Mr. Moore’s was an unnecessary death, caused by the ignorance – perhaps arrogance – of a court that overruled the considered medical judgments of a physician-led team of health providers.”

A VA True Story

- Kimberly Bucklin sentenced to 3 years in state prison for following her doctor's advice
- Probation conditions included no Methadone
- Dr. prescribed medication for OxyContin™ withdrawal
- Commonwealth's Attorney said it was a first

”Cold Turkey” Cruel & Unusual?

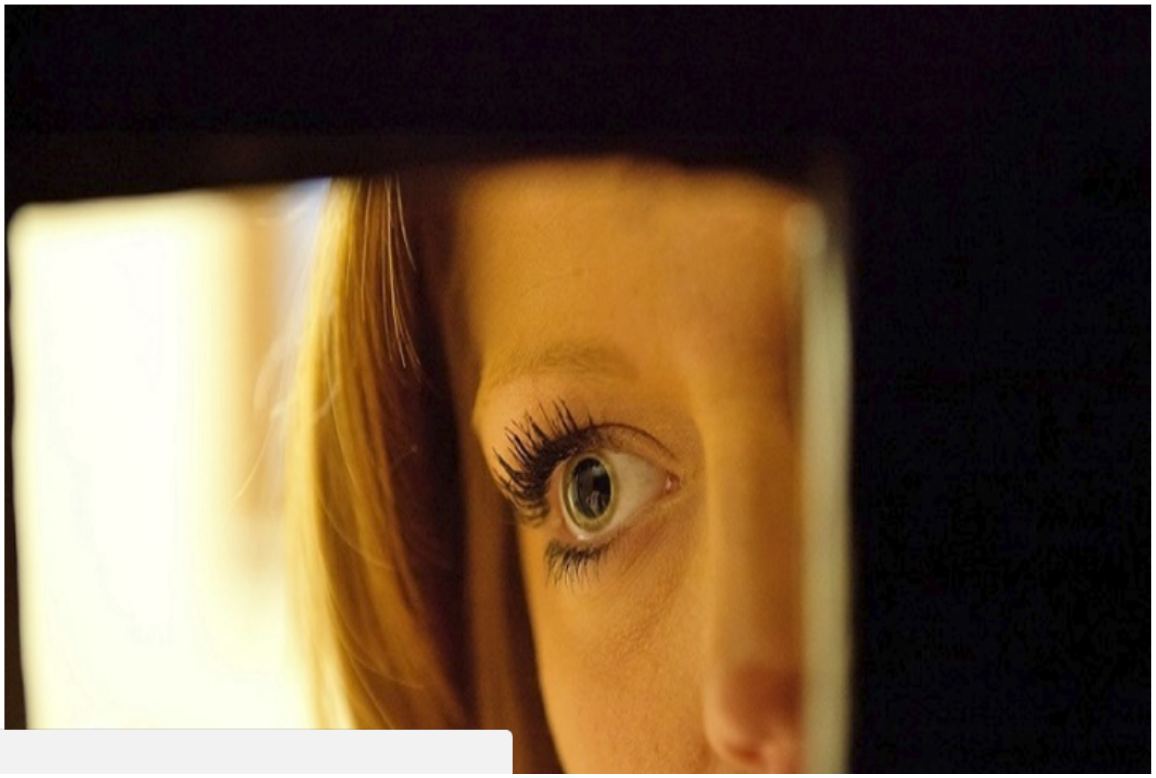
- New Hampshire judge ordered county jail to allow inmate to continue Methadone maintenance. State Supreme Court overturned the judge’s order because it was too costly
- Can sue for failure to provide timely methadone tx in custody (wrongful death while serving 10 days for traffic violation)

Davis vs. Carter 2006 U.S.App. LEXIS 16183 (7th Cir. June 28, 2006)

Ritchie Farrell, Contributor
Author and du-Pont-Columbia Award Recipient

Heroin: Now The Leading Cause Of Death In Americans Under 50

06/06/2017 10:43 am ET | **Updated** Jun 06, 2017



Judge as Doctor?

- Judges shouldn't practice medicine or make pharmaceutical decisions
- It's a crime
- May receive a cease and desist letter

Practicing Bench Medicine

"Determining the appropriate level of care for a particular client must always be done by a duly trained and licensed or certified clinician, such as an addiction counselor, social worker, psychologist, or physician. Under no circumstances should a judge or other nonclinical trained criminal justice professional order a higher or lower level of care than has been determined to be necessary by an ASAM placement or comparable assessment (assuming that the indicated level of care is realistically available). To do so would, in essence, be akin to practicing medicine or another clinical specialty without a license."

The Drug Court Judicial Benchbook, p. 81.

Adult Drug Court Best Practice Standards

- "Participants are prescribed…medications based on medical necessity as determined by a treating physician with expertise in addiction psychiatry, addiction medicine, or a closely related field."
- M.A.T. can significantly improve outcomes.
- Buprenorphine or methadone maintenance administered prior to and immediately after release from custody significantly increases engagement in treatment; reduces illicit opiate use; reduces rearrests, technical parole violations, and incarceration rates; and reduce mortality and hepatitis C infections.
- V. G. Medications

NADCP

- NADCP supported the "no methadone" position for years
- Buprenorphine Fact Sheet published 1999
- Methadone Fact Sheet published April 2002 after one year of negotiations
- "…[M]ethadone patients should not be required to withdraw from a medication that improves their quality of life."

Judge Karen Freeman-Wilson (Ret.)

- "One of our major responses is to train drug courts all over the county…and insist they understand our position on Methadone.
- "It is appropriate for a person to participate and complete a drug court program and be in a methadone clinic."

Tx Provider Bias

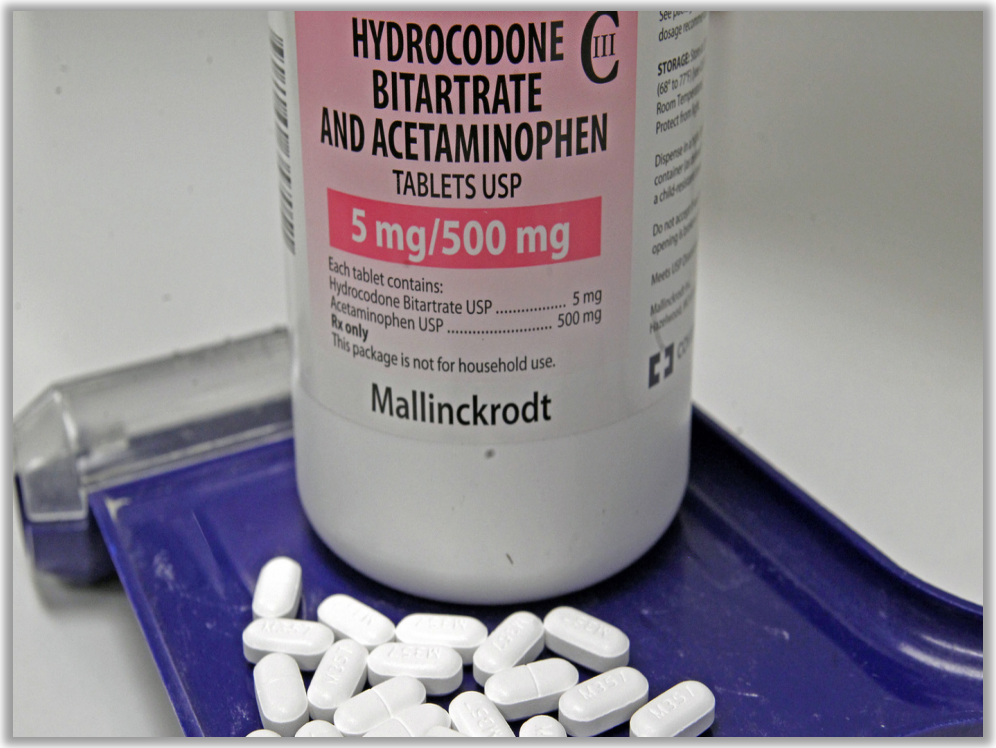
- Tx providers are often themselves recovering
- AA supports Methadone but anyone can say anything in a meeting
- Tx providers may refuse to treat
- Changing with OxyContin™ addiction rates
- More tx providers are now accepting its long-term use

Scope of the problem

- A 2014 survey by NADCP found 20% of adult urban drug courts and 30% suburban drug courts ranked opioids as the primary substance of abuse
- In an earlier survey, 100 drug courts almost half (48%) reported dependency in 20% of their participants

Marlowe, Hardin & Fox, 2016; Matusow, et al., 2013

- Hydrocodone is the #1 prescribed medication in the United States



Misuse of Narcotic Pain Relievers

- 51% of OxyContin® misuse was by first-time users, an indicator of emerging patterns of SA
- Trend is among young people
- Tx admission rates for opioid dependence have more than doubled between 1992 and 2002
- Those entering tx within 3 years of beginning use increased from 26% in 1997 to 39% in 2002
- The need for effective opioid dependence treatment in increasing

Opioid medication

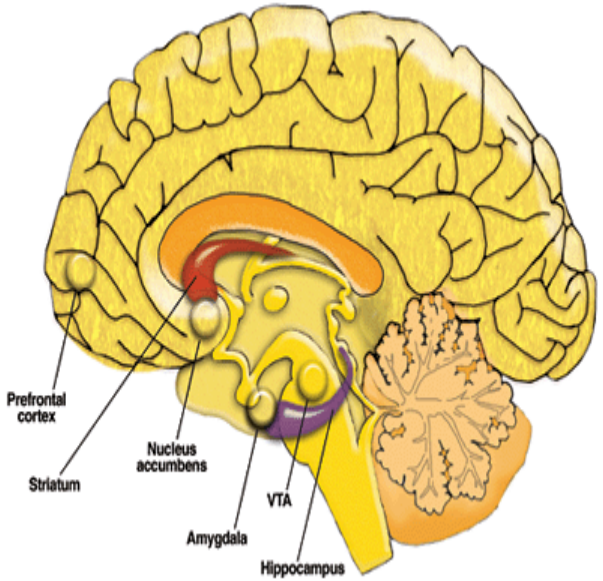
1. Methadone
2. Buprenorphine
3. Naltrexone

- Only 56% of drug courts offer medication
- 50% prohibited buprenorphine and/or methadone

Matusow, et al., 2013

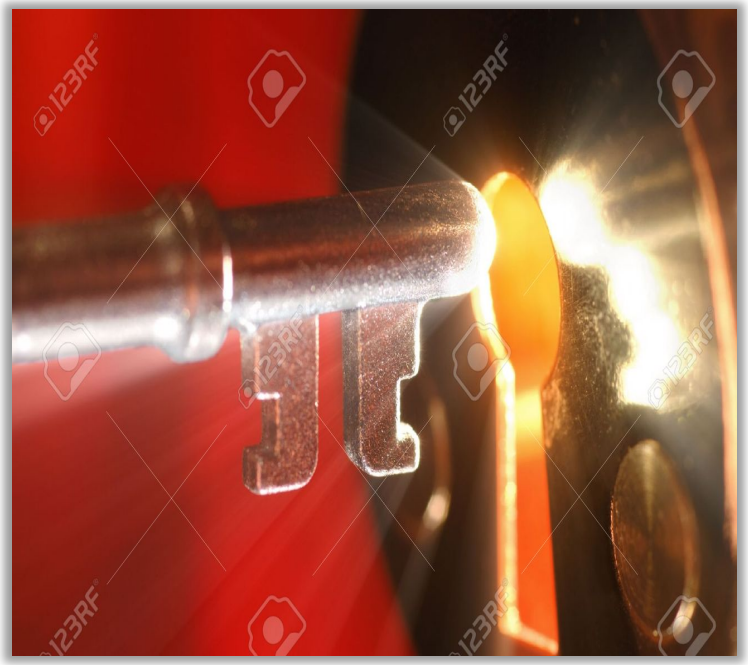
Endorphins

- Endorphins are released as part of the reward and pleasure center of the brain
- Endorphins can also reduce pain



Opioids

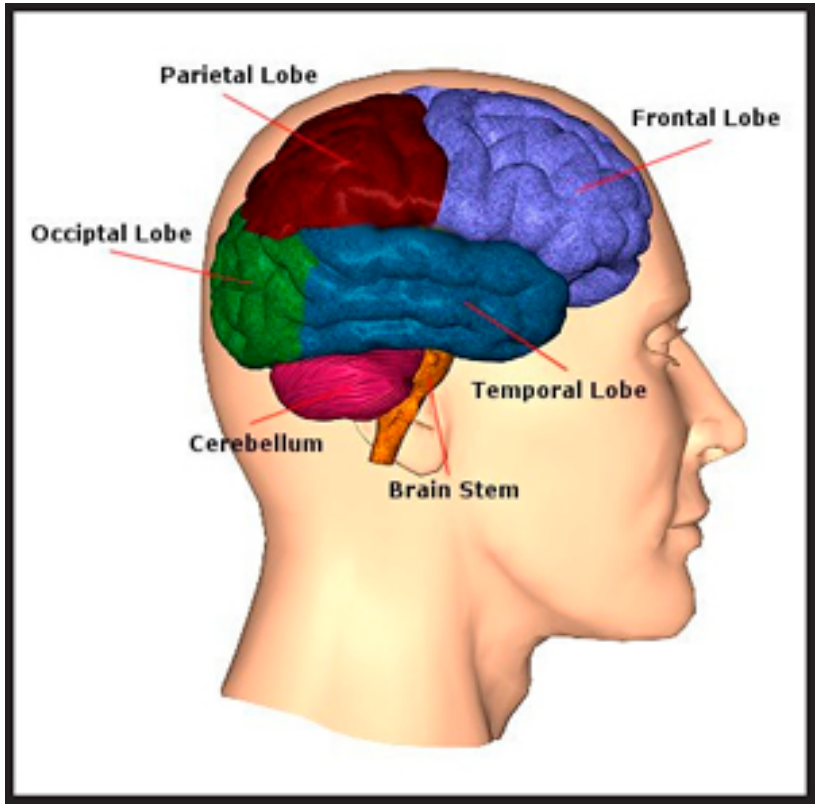
- Similar to endorphins and fit into the same brain receptors
- May stimulate receptor more intensely
- Immediate, reliable and extremely pleasurable



Tolerance

- Receptors can become accustomed to stimulation and reduce their sensitivity
- Person must take larger and larger dose to achieve effect
- Brain lessens its production of its own endorphins
- Ability to experience pleasure is reduced overall
- Anhedonia
- Brain may overproduce norepinephrine that leads to extremely uncomfortable withdrawal symptoms

Frontal Lobe interference



Opioids can interfere with judgment, planning and insight.

TREATMENT FOR OPIOID USE DISORDERS

MAT

- A combination of medication, behavioral or cognitive-behavioral counseling and other psychosocial services is the best treatment for Opioid Use Disorders
- Outcomes are significantly better when psychosocial counseling is delivered in conjunction with MAT
- Best practices require drug courts to monitor participants to ensure psychosocial services are delivered along with MAT

Three types of medications

1. Agonists like methadone
2. Antagonists like naltrexone
3. Partial agonists like buprenorphine

Opioid Agonists

- Mimic effects of endorphins by binding to and activating opioid receptors
- Can produce euphoria and withdrawal in nontolerant people
- Addictive but longer acting and produce less intoxication and sedation
- Methadone

Agonists DO NOT:

- Create euphoria, sedation, or analgesia when taken as a part of a maintenance regime
- Cause a “high” after stabilization
- Cause craving or withdrawal
- Lead to further criminality

It DOES suppress narcotic withdrawal and reduce craving, the main cause of relapse

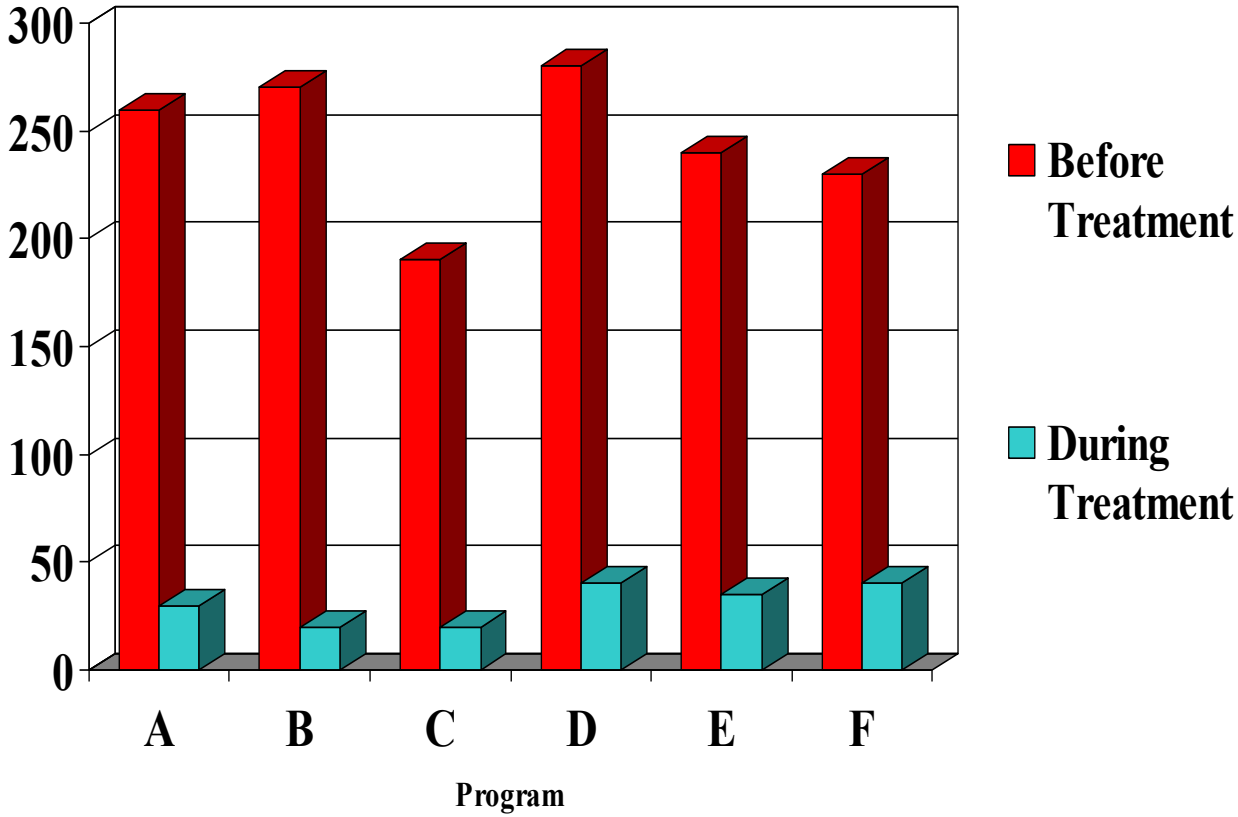
Concerns:

- Unauthorized or inappropriate use
- Clinic locations
- Under medicating
- Relapse rates
- Predators tend to accumulate
- No concurrent counseling

Benefits of Methadone

- Reduces new HIV/AIDS and Hep C rates
- Improves overall general health
- Known amount ingested
- Stabilized physiology, hormones
- Prevents miscarriage from withdrawal
- Reduces criminal behavior

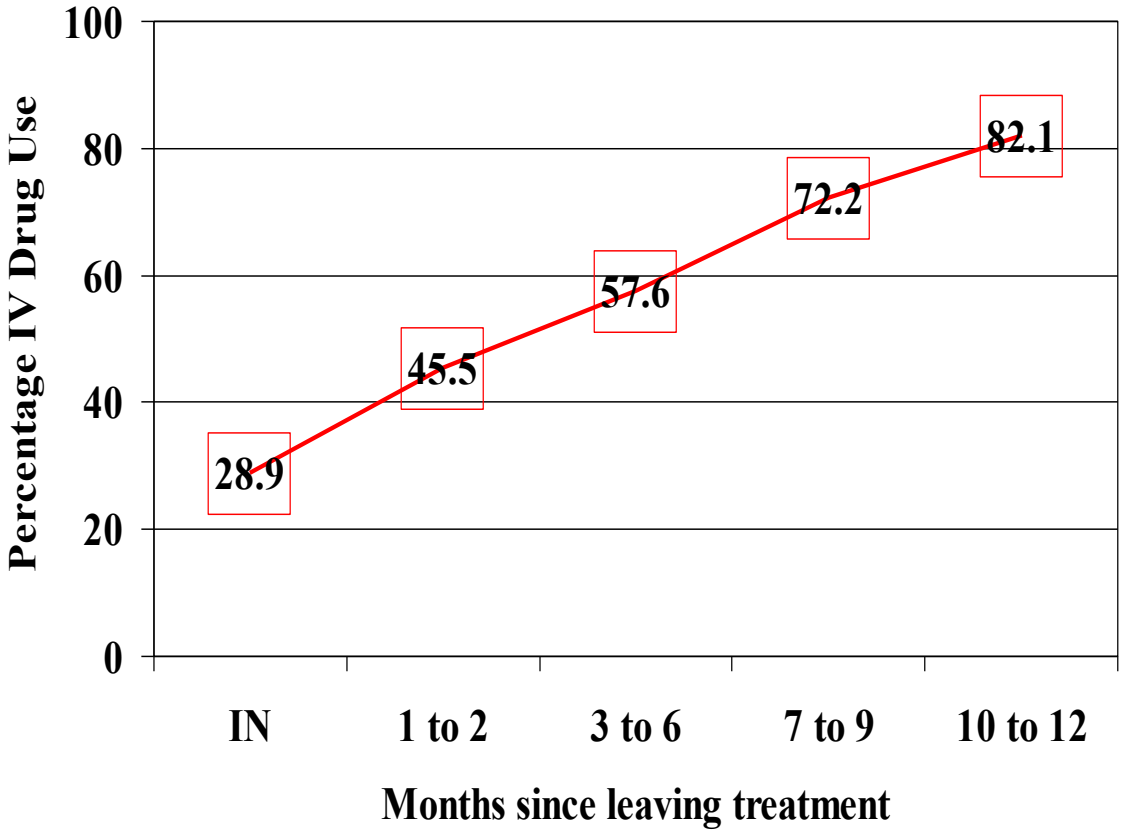
Crime among 491 patients before and during MMT at 6 programs



Adapted from Ball & Ross - *The Effectiveness of Methadone Maintenance Treatment,* 1991

- No long-term negative consequences
- It's been studied for over 40 years
- Lasts 4-6 x's longer than heroin and need only be taken once/day
- Legal
- Avoids needles
- Reduces craving, a major cause of relapse

Relapse to IV drug use after MMT 105 Male patients who left treatment



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MAT Endorsed By

- World Health Organization
- Institute of Medicine
- National Institute of Drug Abuse
- Center for Substance Abuse Treatment
- Department of Health and Human Services
- Office of National Drug Control Policy
- American Society of Addiction Medicine
- National Association of Drug Court Professionals

Long-term Maintenance + Psychosocial Counseling

- More effective than using methadone to detox even if detox is coupled with therapy
- "…[N]o matter how ideologically attractive the notion of a time-limited methadone treatment for heroin abusers, longer-term methadone maintenance treatment is far more effective."

Dr. Sharon Hall, study director, "Methadone Maintenance versus 180-day Psychosocial Detoxification for Treatment of Opioid Dependence: A Randomized, Controlled Trial," (JAMA.2000;283:1303-1310)

Harm of Forced Taper

- Studies show: forced taper **increases risk of relapse and death.** Because opioid tolerance fades rapidly, **one episode of opioid misuse after withdrawal can result in life-threatening or deadly** overdose. (ONDCP, Medication-Assisted Treatment for Opioid Addiction, Sept. 2012).
- SAMHSA recommends: never coerce taper
- Tapering off MAT is not a question of "will" or "moral courage."

Opioid Antagonists

- Antagonists bind with opioid receptor sites but do not stimulate the receptors
- The sit at the sites and block any opioids
- Do not cause euphoria or intoxication
- Requires 7-10 days of total detox before medication can begin
- Can cause withdrawal from opioid medications
- Naltrexone oral form (ReVia or Depade) and injectable (Vivitrol)

Partial Opioid Agonists

- Partially stimulate receptors but also block effects of opioids
- Can treat withdrawal and cravings
- No cravings or intoxication
- Buprenorphine (Subutex, Suboxone, Zubsolv, Bunavail)
- Absorbed sublingually
- OK for pregnant women
- Naloxone combination prevents tampering
- Can be Office-Based Opioid Treatment

Subcutaneous implant of Buprenorphine

- Probuphine®
- Implant lasting 6 months
- Indicated for those who have been stable on transmucosal buprenorphine products.
- Always part of a complete treatment program which includes counseling and psychosocial support.

BEST PRACTICE STANDARDS FOR MAT IN DRUG TREATMENT COURTS

Best Practices

1. Drug courts must permit the use of MAT in appropriate cases
2. NADCP unanimous resolution to:

- Keep an open mind and learn facts about MAT
- Obtain expert medical consultation
- Inquiry into each case to determine if MAT medically indicated or medically necessary
- Explain the court's rationale for permitting or disallowing the use of MAT

Adult Drug Court
Best Practice Standards

- "…[C]andidates are not disqualified from participation …because they have been legally prescribed…addiction medication." Vol. I(I)(E.)
- "Participants are prescribed…addiction medications…by a treating physician with expertise in addiction psychiatry, addiction medicine, or a closely related field." Vol.I(V)(G.)

Other Requirements

- Adult Drug Court Discretionary Grant Program recipients must not deny access because of MAT
- May not require participant to discontinue such medication as a condition of graduation
- Drug court may not overrule physician's determination unless "the court finds that a participant has been misusisng or abusing the medication or diverting the medication for unauthorized purposes."
- No blanket prohibition of MAT is allowed

Remember:

- MAT may include anti depressants, anti psychotics, and other stabilizing medications that assist with recovery.
- The data is unequivocal that we must adapt to MAT if we want good outcomes and participants to live.

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