Opening the Way for Medication-Assisted Treatment in Family Drug Courts

Presenters
Erin Hall MSOT  Hon. Kyle B. Haskins

This project is supported by Award No. 2013‐DC‐BX‐K002 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs. The opinions, findings, and conclusions or recommendations expressed in this publication and those of the author(s) do not necessarily reflect the views of the Department of Justice.

Who is here today?

The Need for Medication-Assisted Treatment (MAT)

1960s  1970s  1980s  1990s  2010s
The Prescription Drug Abuse Problem

- 478 million prescriptions for controlled-substances dispensed in U.S. in 2010
- 7 million Americans reported current non-medical use of prescription drugs in 2010
- In 2010, 2 million people reported using prescription painkillers non-medically for the first time within the last year—nearly 5,500 a day
- 1 in 4 people using drugs for first time in 2010 began by using a prescription drug non-medically
- 6 of top 10 abused substances among high school seniors are prescription drugs

Trends in Emergency Department Visits Involving the Non-medical Use of Opioid Pain Relievers: 2004-2011

ED visits involving the misuse or abuse of opioid pain relievers rose 183% from 2004 to 2011.

Overall Female Treatment Admissions for Other Opiates* as Primary Substance of Abuse

*Other opiates includes non-prescription use of methadone, codeine, morphine, codeinone, hydromorphone, meperidine, opium, and other drugs with morphine-like effects.
ASAM Definition of Addiction

“Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.”

Adopted by the ASAM Board of Directors 4/12/2011

A Chronic, Relapsing Brain Disease

• Brain imaging studies show physical changes in areas of the brain that are critical to
  • Judgment
  • Decision making
  • Learning and memory
  • Behavior control
• These changes alter the way the brain works, and help explain the compulsion and continued use despite negative consequences

Substance Use Disorders are similar to other diseases, such as heart disease. Both diseases disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, are preventable, treatable, and if left untreated, can result in premature death

What is Medication-Assisted Treatment (MAT)?

• MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders (SAMHSA, n.d.)
• MAT is clinically driven with a focus on individualized patient care
• Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful
Three FDA-approved Medications for Opioid Addiction

- Methadone - Dolophine®
- Buprenorphine – Suboxone®, Subutex®
- Naltrexone
  - oral – ReVia®, Depade®
  - extended release injection - Vivitrol®

Opioid Agonist v. Antagonist

- Methadone
  - Access challenges
  - Daily doses at clinic
  - Diversion can be a concern
  - Effectiveness is well documented:
    - Withdrawal symptom suppression
    - Patient retention
    - Reduction of opioid use
    - Reduction of opioid-related health and social problems (i.e. crime)

Source: retrieved from http://www.vivitrol.com/opioidrecovery/howvivitrolworks
Buprenorphine - less chronic dependency - really?
Erin Hall, 8/26/2014
**Buprenorphine**

- Available from primary and generalist physicians with waiver
- Better access
- High effectiveness
- Lower diversion risk (but still some risk)
- No euphoria, lower street value

---

**Naltrexone**

- Monthly dosage
- Can be prescribed by any healthcare provider with prescription authority
- Can only be used with fully detoxified patients, causes immediate withdrawal if opiate still in system
- No diversion risk
- Less effective for opioid addiction (better for alcohol)

---

**How do we know it works?**

As part of a comprehensive treatment program, MAT has been shown to:
- Improve survival
- Increase retention in treatment
- Decrease illicit opiate use
- Decrease criminal activities
- Increase employment
- Improve birth outcomes among opioid dependent pregnant women
Comprehensive Treatment

- Counseling – individual and group
- Drug testing
- Trauma/mental health care
- Primary healthcare
- Intensive case management
- Relapse prevention
- Aftercare
- What else do you consider comprehensive treatment?

Does your FDC provide comprehensive treatment?

If we know MAT works why aren’t FDCs using it?
MAT & Drug Courts

- A recent national survey found that nearly half of drug courts do not use medications in their programs (Matusow et al, 2013)
- One of the primary barriers to using medications was reportedly a lack of awareness of or familiarity with medical treatments
- Need for substantial, targeted educational initiatives to increase awareness of the treatment and criminal justice benefits of MAT in the drug courts

Why the Closed Doors?

1. Misconception of addiction as a moral weakness or willful choice
2. Separation from rest of health care
3. Language mirrors and perpetuates stigma
4. Failure by criminal justice system to defer to medical judgment in treatment

Stigma

- Source: Olsen and Shefstein, JAMA, 2014

Why the Closed Doors?

Lack of knowledge

1. When correctly prescribed and used: methadone does not create a “high”
2. “Using” MAT is similar to “using” Prozac to treat depression or insulin to treat diabetes, not similar to “using” heroin
3. Addiction is a treatable disease of the brain not a moral failing or a choice

How do we incorporate MAT into our family drug court?
Without coordinated responses, families are not well served.

In 2012, the NADCP Board of Directors issued a unanimous resolution:

- Make reasonable efforts to attain reliable expert consultation on the appropriate use of MAT for their participants including partnering with substance abuse treatment programs that offer regular access to medical and psychiatric services.
- Do not impose blanket prohibitions against the use of MAT for their participants and the decision whether or not to allow the use of MAT is based on a particularized assessment in each case.

Policy and Practice Issues

1. Does your FDC have a policy that addresses the use of MAT for parents? Are there conflicting policies in partner agencies (i.e. child welfare)?
2. Does your FDC have a requirement of minimal “dosing” or discontinuance of MAT medications for reunification?
3. Does your FDC use MAT as exclusionary criteria?
4. Does your CWS system have a plan of safe care for infants and mothers affected by opioid use?

Recommendations for FDCs

- Continue to access education for all team members
- Get to know the local options for MAT
- Tour MAT programs and ask for an explanation of their dosing & drug screening practices
- Have client sign Release of Information for MAT provider to facilitate information sharing
- Create a written policy for MAT
- Establish communication protocols across SA counselors, MAT providers, court, child welfare and other team members
- Invite MAT providers to participate in FDC staffings
**Considerations for MAT policy for FDCs**

- Admission criteria – MAT should not be an exclusionary criteria
- Comprehensive Services – MAT should be paired with
  - Counseling,
  - Drug testing and monitoring,
  - Intensive case management and support (housing, employment, etc)
- Aftercare

**Considerations for MAT policy for FDCs, Con’t**

- Coordination and communication with prescribing physicians including:
  - Type of medication, dosage and frequency
  - Attendance at scheduled appointments
  - Parent behavior and patterns of concern
- Communication from FDC to physician
  - Requirements of FDC participation
  - Parent behavior and patterns of concern (may indicate need to adjust dosage)

**Special Considerations for Pregnant Women**

- Linkages with other agencies – do partners have outdated and conflicting MAT policies?
- Compliance monitoring - specify who and how will this be accomplished?
- Responses to behavior – therapeutic, with consideration for stage of recovery, phase in FDC, etc.
• Current (2012) standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone
• NAS is an expected and treatable condition that follows prenatal exposure to opioid agonists


MOTHERS Study
The first randomized controlled trial data to support the safety and efficacy of buprenorphine. Findings include:
- Maternal outcomes, pain management considerations, and breastfeeding recommendations are similar between medications.
- Buprenorphine is an effective option for pregnant women who are new to treatment or maintained on buprenorphine pre-pregnancy.

Hendree Jones, Presented at the NADCP Annual meeting, May 28, 2014, Anaheim, CA.
Children and Recovering Mothers (CHARM) Overview

- A multidisciplinary group of agencies serving pregnant women with opiate addiction and their infants
- Provides comprehensive care coordination for pregnant women with opiate addiction and consultation for child welfare, medical, and addiction professionals across the state of Vermont
- The CHARM collaborative serves about 200 women and their infants annually.

Key Elements of CHARM

- In person meeting 2 hours each month
- Two year effort to create Memorandum or Understanding
- Team effort to engage women and get release of information signed

Key Elements of CHARM

- Child welfare can begin providing services 30 prior to due date
- State statute allows for Child Safety Teams to act on behalf of child safety
- 24/7 telephone support for families with infants needing methadone at home

Opening the Doors in Family Drug Courts

The Tulsa Experience

Hon. Kyle B. Haskins
Has the Tulsa County FDC always been open to MAT?

What were some of the key barriers in accepting MAT clients in your FDC?

Why is it recommended that FDCs not consider MAT as an exclusionary criteria?

What are some approaches in educating CWS, AOD, and Courts regarding MAT?
What are next steps in regards to policy and practice involving MAT clients in your FDC?

Next Steps & Resources

To download, please visit:

Resource

Legality of Denying Access to Medication Assisted Treatment in the Criminal Justice Center (Legal Justice Center, December 2011)

Resource

Adult Drug Court Best Practices Standards, Section G, “Medications”, page 44

Resource

Drug Court Judicial Benchbook, VI, Section 4.14, "Addiction Medicine", page 76
To download, please visit:

FDC LEARNING ACADEMY WEBINAR SERIES
THIS CHANGES EVERYTHING

March 6th
Tested and Proven – Utilization of Recovery Support Specialists as a Key Engagement and Retention Strategy in FDC (and Beyond)

April 10th
Our Grant is Over – Now What? Re-financing and Re-Directing as Real Sustainability Planning for Your FDC

June 19th
Closed Doors or Welcome Mat? Opening the Way for Medication-Assisted Treatment in FDC

July 10th
So How Do You Know They Are Really Ready? Key Considerations for Assessing Families in Recovery for Reunification

Aug. 14th
Exploring Solutions Together – The Issue of Racial and Ethnic Disproportionality in FDCs

Sept. 18th
Matching Service to Need – Exploring What “High-Risk, High-Need” Means for FDCs

Contact Information

Erin Hall, MSOT
Program Associate
Children & Family Futures
25371 Commercentre Dr.
Suite 140
Lake Forest, CA 92630
(714) 505-3625
ehall@cffutures.org

Hon. Kyle B. Haskins
Tulsa County Juvenile Bureau
315 S. Gilcrease Museum Rd.
14th Judicial Dist., State of OK
Tulsa, OK 74127
918-596-0926
kyle.haskins@oscn.net

This Changes Everything - 2014