



Medication Assisted Treatment

Approximately 2.1 million Americans were addicted to prescription opioid pain medicines, and opioid overdose deaths increased fivefold over the last 15 years.

Opioid use disorder (OUD) is common in criminal justice populations, and people with OUD are up to 13 times more likely to be involved in the criminal justice system as compared with people who do not suffer from OUD. Within the first two weeks of release from incarceration, an individual is 12 times more likely to die from a fatal overdose than other individuals with OUD. This is because a period of abstinence from a drug causes a person to lose tolerance for the drug. Moreover, untreated OUD also contributes to additional criminal activity and risky behavior, and therefore, to reincarceration.

Using medication assisted treatment (MAT) in conjunction with counseling and psychosocial supports is a good practice in quelling continued opioid use upon entry into criminal justice settings. MAT utilizes Food and Drug Administration (FDA)-approved medications to treat OUD that include methadone, buprenorphine, and naltrexone. These medications have been associated with significantly reduced use of unauthorized opioids among probationers, parolees, and other persons with OUDs in the justice system.

BASICS OF MAT IN COURT SETTINGS (Adapted from KY MAT Benchmark)

A. There can be no Blanket Refusals of MAT in any Court.

- Drug addiction is a recognized disability under (1) Title II of the Americans with Disabilities Act (ADA), which applies to the operations of local and state governments, and (2) the Rehabilitation Act, which applies to entities receiving federal funding.¹
- If an individual has a disability then courts are required to make reasonable modifications to the program, service, or activity to accommodate the individual.
- Public entities can be held liable for violations of the ADA.²
- Blanket refusals of MAT by a court will almost always be classified as discrimination if the individual has a disability. MAT is considered a service under the ADA.

C. Individualized Inquiry

- The current illegal use of drugs must have occurred recently enough to justify a reasonable belief that a person's drug use is current or that continuing use is a real and ongoing problem.⁴
- “A drug rehabilitation or treatment program may deny participation in its program to individuals who engage in illegal use of drugs while they are in the program.”⁵

Specialty courts are considered treatment and these courts can sanction or terminate the participant from the program based on the current illegal use of drugs BUT cannot deny MAT if the individual is entitled to MAT.

B. Current Illegal Use of Drugs

A court cannot deny MAT, which is considered a health or rehabilitative service under the ADA, on the basis that the individual is engaged in the current illegal use of drugs if the individual is otherwise entitled to the service; however, the court can deny other services or benefits, such as denying probation, work release, or child custody privileges because of current illegal use of drugs.³

C. Individualized Inquiry

A court can either (1) permit the MAT that has been prescribed or (2) conduct an individualized inquiry and determine whether to permit or deny individuals to utilize MAT in its programs, services, or benefits. At the individualized inquiry, the court shall:^{6,7}

1. Hold a confidential hearing on the record and seal the hearing record;
2. Receive information and/or testimony from the prescribing physician or otherwise qualified medical expert;
3. Consider relevant information before making a finding; and
4. Articulate the rationale in writing if the court denies the individual's use of addiction medication in its programs, services, or benefits.

FINDING QUALITY MEDICATION ASSISTED TREATMENT (MAT) PROGRAMS (Adapted from the NDCI Grant Questions)

1. Does the program philosophically support all forms of MAT approaches to recovery?
2. Does the program have a MAT prescribing physician / nurse practitioner / physician assistant on staff?
 - 2a. What forms of MAT can staff prescribe or administer?
 - 2b. Are prescribers available during all business hours or only a limited number of hours?
 - 2c. How long have these medications been used by the prescribing medical staff?
 - 2d. How many existing patients within the program receive MAT?
 - 2e. Does staff have the ability to provide crisis services or refer to these services 24/7?
3. What addiction medications are currently available to the program's community MAT provider network?
4. Does the program follow nationally recognized protocols for MAT patients consistent with federal and state guidelines?
5. Does the program have a uniform MAT taper, length of time requirement, or other policy that is inconsistent with MAT evidence-based principles?
6. What communication protocols are in place with MAT prescribing physicians or other medical staff (both onsite and offsite) to ensure that there is adequate communication regarding patients' MAT compliance and progress?
7. What types of evidence-based psychosocial treatments (e.g., cognitive behavioral therapy, contingency management) are available to MAT patients?
8. What other behavioral health and social services are available for MAT patients?
 - 8a. If these services are not available, does the provider have an adequate referral network?
 - 8b. As a practice of regular business, does the provider utilize release of information agreements to effectively communicate with partners when clinically appropriate?
9. What is the program's funding source for MAT services (e.g., self-pay, Medicaid, private insurance, grant, etc.)?
10. Is the provider licensed and/or certified by all appropriate federal and state authorities?
 - 10a. If so, is the provider in good standing with these authorities?
11. Does the provider have patient-centered treatment plans for patients including a written treatment agreement with strategies for preventing medication diversion, including (but not limited to): random pill counts, frequent random urine drug screens; and PDMP checks as required by federal and state laws and according to nationally recognized guidelines?
12. Does the provider have adequate strategies for patient relapse and retention during treatment?
13. Do staff receive regular training on substance use disorders and related issues (e.g., fundamentals of addiction and treatment, stigma reduction, trauma-informed care)?
14. Do a majority of patients successfully complete the program or are they able to be maintained on MAT for long-term recovery?

REFERENCES FOR FURTHER READING

- American Society for Addiction Medicine: <https://www.asam.org/>
- Centers for Disease Control and Prevention: <https://www.cdc.gov/drugoverdose/index.html>
- National Center for State Courts: <https://www.ncsc.org/opioids>
- National Institute of Health: <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/addiction/effective-treatments-opioid-addiction>
- National Judicial Opioid Task Force: <https://www.ncsc.org/~media/CA7C3ABF246646C28C43D048429A89F4.aslx>
- Surgeon General: <https://addiction.surgeongeneral.gov/>

Notes

- ¹ 42 U.S.C. § 12132; 29 U.S.C. § 794.
- ² Tennessee v. Lane, 541 U.S. 509 (2004).
- ³ 28 C.F.R. § 35.131(b).
- ⁴ 28 C.F.R. § 35.104.
- ⁵ 28 C.F.R. § 35.131(b)(2).
- ⁶ NADCP INSTITUTE (NDCI), Drug Court Practitioner Fact Sheet, August 2016, Vol. XI, No. 2.
- ⁷ Sup. R. 45.

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