Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence

More than 2,700 drug courts are in operation today in the United States.[1] About half of these are adult drug treatment courts. Developed to decrease recidivism among substance-involved offenders, adult drug courts oversee substance use disorder treatment for criminal offenders accepted into these programs.

Many drug court participants need treatment for opioid dependence. Medications can be an important part of effective treatment for offenders dependent on opioids,[2] decreasing craving and withdrawal symptoms, blocking euphoria if relapse occurs, augmenting the effect of counseling, and reducing recidivism and reincarceration.[2,3]

Many national and international professional bodies consider medication-assisted treatment (MAT) with methadone, buprenorphine, or extended-release injectable naltrexone an evidence-based best practice for treating opioid dependence. However, many drug courts do not recommend (or even allow) the use of MAT for opioid dependence. For example, a 2010 survey of 103 drug courts found that, whereas 98 percent reported that at least some of their drug court participants were opioid dependent, only 56 percent of the courts offered any form of MAT to participants.[4]

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Extent of Opioid Use

Data from the 2012 National Survey on Drug Use and Health (NSDUH) indicate that the number of people reporting past-year use of heroin has steadily increased since 2007. Past-year heroin use was reported by 669,000 people, 467,000 reported dependence on or abuse of heroin.[9]

Nonmedical use of pain relievers continues to be more widespread than heroin use. Nearly 1.9 million people initiated nonmedical use of opioid pain relievers in 2012, second only to the number of those initiating use of marijuana, and 2.1 million reported dependence on or abuse of pain relievers (second only to marijuana).[9]

The problem of opioid use is greater among those involved with the criminal justice system than among the general population. Precise information about drug court

participants and opioid abuse is scarce, but one study found that:[10]

- Seven percent of participants entering urban drug court programs named illicit opioids as their primary drug of abuse.
- Ten percent of participants entering suburban drug court programs named illicit opioids as their primary drug of abuse.
- Twelve percent of rural participants named illicit opioids as their primary drug of abuse.

Matusow et al.[4] found that, following the national trend, more drug court participants reported nonmedical use of prescription opioids (66 percent) than reported use of heroin (26 percent). This trend was more pronounced in rural and suburban areas than in urban areas.

The 2012 NSDUH reports that:[9]

- Of individuals on parole or other supervised release from prison, 7.0 percent reported current nonmedical use of psychotherapeutic drugs (including opioid pain relievers), compared with 2.6 percent of adults not on parole or supervised release.
- Of those on probation, 10.1 percent reported current nonmedical use of psychotherapeutic drugs, compared with 2.4 percent of adults not on probation who reported nonmedical use of psychotherapeutic drugs.

Although the NSDUH does not list speciýc psycho-

drug courts nationwide on drug court practices and found low use of methadone maintenance therapy among drug courts.[15] Approximately two-thirds (67.5 percent) of courts indicated that detoxiýcation was available. However, only 20.9 percent offered methadone-to-abstinence treatment, and only 18.0 percent stated that methadone maintenance was available. Further, many drug court programs will not admit individuals who are already using methadone.[15]

Medications have developed remarkably over the

Effectiveness of methadone

When doses are appropriate, methadone improves treatment retention and, as a result, decreases relapse and the health and criminal problems associated with illicit opioid use.[20] Long-term methadone maintenance therapy is more effective than either detoxiýcation with methadone or medication-free treatment in decreasing heroin use and retaining patients in treatment.[17,21] A review of the literature showed that, in 11 clinical trials involving 1,969 people, methadone improved treatment retention and reduced heroin use compared with nonmedication treatment.[17] Bhati et al.[22] found that if outpatient methadone treatment were expanded to all eligible offenders, 3.3 million nondrug crimes could be averted. Every dollar spent on ongoing methadone treatment yields almost $38 in beneýts through reduced crime, better health, and gainful employment.[23]

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be withdrawn from all opioids for 7 to 10 days before receiving extended-release injectable naltrexone, or he or she will undergo withdrawal symptoms immediately.

Extended-release injectable naltrexone is not a controlled substance and has no abuse or diversion potential, offering an alternative to agonist therapy with methadone or buprenorphine as well as expanding access to MAT.

Extended-release injectable naltrexone is relatively safe and well tolerated. Major adverse effects include severe, acute precipitated opioid withdrawal (if the patient is not fully detoxiýed), risk of injection site problems, and the potential for adverse liver effects if given in "excessive doses"; it is contraindicated for patients with acute hepatitis or liver failure.[29]

Effectiveness of extended-release injectable naltrexone

Extended-release injectable naltrexone has not been studied for as long as either methadone or buprenorphine, but research indicates that it is a promising treatment for opioid dependence. For example, studies have found that the injectable form of naltrexone can improve patient adherence to the medication and increase treatment retention.[18,30,31] Treatment retention is particularly important because it provides clinicians sufýcient time to engage patients in psychotherapy or counseling so that they can learn to make psychological and social adjustments that support a life without opioids.

- Develop relationships with behavioral health facilities that can provide integrated treatment for drug court participants who have co-occurring substance use and mental disorders (or with professionals who have experience working as part of integrated care teams).
- Consult regularly with treatment professionals; use their expertise to set the best course for each drug court participant.
- Identify local physicians who can prescribe buprenorphine and extended-release injectable naltrexone and who are willing to coordinate such care with drug court staff.
- Work with local substance abuse coalitions to educate the community and change attitudes about the treatment of opioid dependence, to increase understanding of MAT and change drug court policies.

Resources

Web Resources

American Association for the Treatment of Opioid Dependence
http://www.aatod.org

American Society of Addiction Medicine
http://www.asam.org

Behavioral Health Treatment Services Locator
http://ýndtreatment.samhsa.gov

Notes

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[11] National Association of State Alcohol and Drug Abuse Directors, Inc. (2013). *Consensus statement on the use of medications in treatment of substance use disorders* (Conclusion). Retrieved June 16, 2014, from http://nasadad.org/wp-content/uploads/2013/01/13-January-15-NASADAD-Statement-on-MAT.pdf

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