Drug Courts and MAT Ethical Considerations

Steve Hanson
Associate Commissioner
NYS OASAS
Drug Court Resistance to MAT

• Not “real recovery”
• Trading one addiction for another
• It just makes pharmaceutical companies rich
• Must try abstinence first
72,000 People Died from Overdose in 2017
Estimated Age-adjusted Death Rates§ for Drug Poisoning by County, United States: 2016
Estimated Age-adjusted Death Rates for Drug Poisoning by County, United States: 2016
Patient Needs

**Diabetes**
- Some can control with diet
- Some can control with medication
- Some are insulin dependent
- Without adequate treatment - many will die

**Opiod Addicts**
- Some can quit on own
- Some can remain abstinent with “regular” treatment
- Some need ORT
- Without adequate treatment - many will die
Alive is Good!
Opioids

- Morphine
- Heroin
- Codeine
- Fentanyl
- Oxycontin
- Vicodin
- Hysingla
- Others
Non-Opioid-Dependent and Opioid-Dependent Brain Images

PET scan images show changes in brain function caused by opioid dependence. The lack of red in the opioid-dependent brain shows a reduction in brain function in these regions.

Pharmacology of Addiction

Drugs can change the brain in fundamental and long lasting ways
Brain Changes
This is Your Brain on Drugs

Non-Opioid-Dependent and Opioid-Dependent Brain Images

PET scan images show changes in brain function caused by opioid dependence. The lack of red in the opioid-dependent brain shows a reduction in brain function in these regions.

Opiates Increase DA Release
MORPHINE

% of Basal Release

Time After Morphine

Source: Di Chiara and Imperato
Heroin/Opioids

**Effects**
- Analgesia - change in pain perception
- Euphoria - Intense
- Sedation - “on the nod”
- Respiratory Depression
- Cough Suppression
- Nausea/vomiting
- Constipation

**Withdrawal**
- Pain
- Depression
- Alert
- Rapid Breathing
- Coughing
- Nausea/Vomiting
- Diarrhea
- 3-5 days
Addiction/Dependency Cycle

• Opioids trigger reward system – euphoria – leads to continued use – addiction

• Withdrawal symptoms are significant – regular use to avoid withdrawal - dependence
Potency

OPIOID POTENCY

Carfentanil: 10,000x
Fentanyl: 100x
Heroin: 2x
Morphine: 1x

NIDA
What is effective treatment?

**Pharmacotherapy**
- Methadone
- Buprenorphine
- Naltrexone

**Recovery Support**
- AA, NA, SMART Recovery
- Recovery Coaches

**Psychosocial Interventions**
- CBT, MI, CM
Does Treatment Work?

- Medications + psychosocial therapy *both* benefit brain function and recovery.
- Each affects *different parts* of brain and in *opposite ways*.
Federal Position

• Drug courts that receive federal dollars will no longer be allowed to ban the kinds of medication-assisted treatments that doctors and scientists view as the most effective care for opioid addicts, Botticelli announced in a conference call with reporters. (Michael Botticelli ONDCP Director)

• "We've made that clear: If they want our federal dollars, they cannot do that. We are trying to make it clear that medication-assisted treatment is an appropriate approach to opioids." (Pamela Hyde, SAMHSA’s Administrator)
BJA Grants

Applicants must demonstrate that the drug court for which funds are being sought will not:

1. deny any appropriate and eligible client for the drug court access to the program because of their **medically necessary** use of FDA-approved medication assisted treatment (MAT) medications (methadone, injectable naltrexone, non-injectable naltrexone, disulfiram, acamprosate calcium, buprenorphine) that is in accordance with an appropriately authorized physician's prescription; and

2. mandate that a drug court client no longer use **medically necessary** MAT as part of the conditions of the drug court if such a mandate is inconsistent with a physician's recommendation or prescription. Under no circumstances may a drug court judge, other judicial official, or correctional supervision officer connected to the identified drug court deny the use of these medications when **medically necessary** and when available to the clients and under the conditions described above.
RESOLUTION OF THE BOARD OF DIRECTORS
ON THE AVAILABILITY OF MEDICALLY ASSISTED TREATMENT (M.A.T.)
FOR ADDICTION IN DRUG COURTS

NOW, THEREFORE, BE IT RESOLVED THAT:

1. Drug Court professionals have an affirmative obligation to learn about current research findings related to the safety and efficacy of M.A.T. for addiction.

2. Drug Court programs should make reasonable efforts to attain reliable expert consultation on the appropriate use of M.A.T. for their participants. This includes partnering with substance abuse treatment programs that offer regular access to medical or psychiatric services.

3. Drug Courts do not impose blanket prohibitions against the use of M.A.T. for their participants. The decision whether or not to allow the use of M.A.T. is based on a particularized assessment in each case of the needs of the participant and the interests of the public and the administration of justice.
Medication for Addiction Treatment (MAT)

- **Opioid Agonist Therapy**
  - Methadone Maintenance
  - Buprenorphine Maintenance

- **Opioid Antagonist**
  - Long-Acting Naltrexone
Pharmacology of Treatments
Opioid Agonist Therapy

1. What are the goals of opioid agonist therapy?
2. What do these treatments look like in community?
3. How well do they work?
What are goals of opioid agonist therapy?

Methadone and Buprenorphine
What are goals of opioid agonist therapy?

Methadone and Buprenorphine

Prevent Withdrawal Symptoms
Long Duration of Action = Stable Effect
No “euphoria” or “high” at stable dosing
What are goals of opioid agonist therapy?

Methadone and Buprenorphine

- Prevent Withdrawal Symptoms
- Reduce Cravings
What are goals of opioid agonist therapy?

Methadone and Buprenorphine

- Prevent Withdrawal Symptoms
- Reduce Cravings
- Block Effects of Exogenous Opioids
What are goals of opioid agonist therapy?

**Methadone and Buprenorphine**
- Prevent Withdrawal Symptoms
- Reduce Cravings
- Block Effects of Exogenous Opioids

Prevent relapse and allow brain to slowly heal
What does effective opioid agonist therapy look like?

“I have money in my pocket. I feel good about myself when I wake up each day. I don't think about heroin. And I feel like I have my life back.”

~ patient
Are methadone or buprenorphine simply trading one addiction for another?
Addiction

- Escalating use over time
- Loss of control; inability to stop
- Use despite negative consequences
- Unable to fulfill societal obligations

Dependence

- Presence of withdrawal symptoms if substance stopped abruptly

*Methadone and buprenorphine result in physical dependence but not addiction.*
The Medication stopped the dependence from screaming in my ear.
Opioid Agonist Therapy

1. What are the goals of opioid agonist therapy?

2. What do these treatments look like in community?

3. How well do they work?
### Methadone vs. Buprenorphine

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<th>Duration</th>
<th>Frequency of Visits</th>
<th>Additional Services</th>
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<tr>
<td>METHADONE (OTP)</td>
<td>Dispensed onsite by nurse</td>
<td>24-36 hours</td>
<td>Daily*</td>
<td>Counseling Recovery Groups +/- Mental Health</td>
</tr>
<tr>
<td>BUPE (Clinic (SEP, IOP OTP))</td>
<td>Rx to Pharmacy (provider needs x-waiver)</td>
<td>24-36 hours</td>
<td>Weekly q2 Weeks Monthly</td>
<td>+/- Counseling (varies by clinic)</td>
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* Visit frequency at an OTP starts at daily (6 days/week + 1 take-home on Sundays) first 90 days and patients are given take-home bottles and less frequent visits as they stabilize in treatment.
Intensity of Treatment

Slide courtesy of Dr. Aaron Fox
Pros & Cons

**Methadone**
- Best Evidence
- Structure & Support
  - ↓ Rearrest
- Access
  - Regulations
  - Stigma

**Buprenorphine**
- ↓ Opioid Use
- Better Safety Profile
  - Flexibility
- Access
  - Less Structure
  - Diversion / Cost
Opioid Agonist Therapy

1. What are the goals of opioid agonist therapy?

2. What do these treatments look like in community?

3. How well do they work?
Important Questions When Considering Effectiveness

1. Effective for whom?
   a. Community dwelling? Justice-involved? Those who have completed detox programs? Those seeking treatment? Those seeking a specific type of treatment?

2. Compared to what?
   a. Compared to detoxification and counseling?
   b. Compared to other pharmacotherapies?

3. Which outcomes matter?
Opioid Detoxification Ineffective

83% relapsed at 30 days

Compared to 1st Attempt:
- 2nd attempt 32% less likely
- 3rd attempt 44% less likely
- 4th attempt 47% less likely
- 5th attempt 59% less likely
Buprenorphine is Effective at Retaining Patients in Treatment & Preventing Relapse

Kakko et al. Lancet. 2003 Feb 22;361(9358):662-8
Buprenorphine is Effective at Retaining Patients in Treatment & Preventing Relapse

“The review of trials found that buprenorphine at high doses (16 mg) can reduce illicit opioid use effectively compared with placebo, and buprenorphine at any dose studied retains people in treatment better than placebo.”
Buprenorphine Rx associated with ↓ Heroin Use

Interim Buprenorphine vs. Waiting List for Opioid Dependence

Methadone is Effective at Retaining Patients in Treatment & Preventing Relapse

“Methadone is an effective maintenance therapy intervention for the treatment of heroin dependence as it retains patients in treatment and decreases heroin use better than treatments that do not utilize opioid replacement therapy.”
Mortality Decreased

**All cause** mortality rates (per 1000 per/yr)
- In methadone treatment: 11.3
- Out of methadone treatment: 36.1
- In buprenorphine treatment: 4.3
- Out of buprenorphine treatment: 9.5

**Overdose** mortality rates:
- In methadone treatment: 2.6
- Out of methadone treatment: 12.7
- In buprenorphine treatment: 1.4
- Out of buprenorphine treatment: 4.6
Relapse & Cost Reduced with Methadone and Buprenorphine

- Relapse reduced by 50%
- Costs $153 to $223 lower per month

Slide courtesy of Dr. Sarah Wakeman
How about in correctional setting?

Risks of OUD

11x ↑ Risk of death in first 2 weeks of reentry

129x ↑ Risk of OD Death in first 2 weeks of reentry

Benefits of OAT

75% ↓ Risk of death in first 4 weeks of reentry

85% ↓ Risk of OD death in first 4 weeks of reentry

Binswanger NEJM 2007

Marsden Addiction 2017
Medication for Addiction Treatment (MAT)

- **Opioid Agonist Therapy**
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  - Long-Acting Naltrexone
# Injectable Long-Acting Naltrexone

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<tr>
<td>NALTREXONE</td>
<td>Varies IM Injection (30 days)</td>
<td>Varies</td>
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### Treatment Initiation Process Varies

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<th>Initiation of Treatment</th>
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<tr>
<td><strong>Methadone</strong></td>
<td>Done at OTP</td>
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<tr>
<td></td>
<td>+Withdrawal Symptoms</td>
</tr>
<tr>
<td></td>
<td>(6-12 hours since last illicit opioid use)</td>
</tr>
<tr>
<td><strong>Buprenorphine</strong></td>
<td>Home or Office Based</td>
</tr>
<tr>
<td></td>
<td>+Withdrawal Symptoms*</td>
</tr>
<tr>
<td></td>
<td>(6-12 hours since last illicit opioid use)</td>
</tr>
<tr>
<td><strong>IM Naltrexone</strong></td>
<td><em>Must complete 7-10 day detoxification prior...</em></td>
</tr>
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Is naltrexone (XRN) effective?

1. XRN vs. Placebo RCT (Lancet 2011)
   a. Setting: Russia; Funder: Alkermes
   b. Enrolled patients post-detoxification (≥7 days since last use)
   c. Outcome: XRN: ↑ retention; ↑ opioid free weeks; ↓ cravings

2. XRN vs. Usual Care RCT (NEJM 2016)
   a. Setting: USA; Funder: NIDA; Alkermes donated XRN
   b. Enrolled justice-involved pts preference for “opioid free” tx
   c. Outcome: XRN: ↑ time to relapse (10.5 weeks vs 5.0 weeks)
Methadone Effectiveness
Gunne & Gronbladh, 1984

Baseline

Methadone | Regular Outpatient Rx.
---|---
H H H H | H H H H
H H H H | H H H H
H H H H | H H H H
H H H H | H H H H
H H H H | H H H H
H H H H | H H H H
H | H

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Methadone Effectiveness
After 2 Years

<table>
<thead>
<tr>
<th>Methadone</th>
<th>No Methadone</th>
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<tbody>
<tr>
<td><img src="image.png" alt="Diagram" /></td>
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</table>

1- Sepsis & endocarditis
2- Leg amputation
3- Sepsis
Methadone Effectiveness

After 5 Years

Methadone  No Methadone
Buprenorphine
A tragic appendix: Mortality

Heilig, Lancet 2003

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>BPN</th>
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<tbody>
<tr>
<td>Dead</td>
<td>4/20 (20%)</td>
<td>0/20 (0%)</td>
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