
Medication Assisted Treatment: Implications for Judges and Court

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September 4, 2015 - 11 AM – 12:15 PM Norman, OK
Oklahoma Specialty Court Conference

A. Terminology and Why include 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).

Transitional terms to help the general public, recipients of health care services, and professional health care service providers understand that pharmacotherapy can be helpful in supporting recovery. The manifestations of addiction-related problems are addressed in their biological, psychological, social, and spiritual dimensions during addiction treatment, in treatment approaches that are abstinence-based, and in treatment approaches that are harm-reduction-based.

Medication Assisted Recovery (MAR) is one component of the treatment and recovery process. Medication Assisted Treatment (MAT), another variation on the concept of MAR, may involve pharmacotherapy alone. It is essential that addiction treatment and recovery approaches address the various aspects of biological, psychological, social, and spiritual dimensions for optimum health and wellness. It is hoped that as the public and professionals recognize that recovery and treatment need to be holistic, appropriate pharmacotherapy would be well accepted as part of treatment and recovery, such that the terms MAR and MAT would be deemed unnecessary. (*The ASAM Criteria* 2013, p. 421)

1. ASAM’s Definition of Addiction

- The Definition of Addiction adopted by the ASAM Board of Directors in April 2011 states that persons with addiction can be seen as “pathologically pursuing reward and/or relief by substance use and other behaviors.”
- The qualitative difference between individuals who have addiction and those who do not is that persons with addiction manifest a pathological pursuit of reward or relief, and have a “disease of brain reward, motivation, memory and related circuitry” which is “characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response.”

2. Why Even Consider MAT – Range of MATs

(a) Pharmacotherapy for Substance Use Disorders

- Medication-Assisted Treatment (MAT) is a form of pharmacotherapy and refers to any treatment for a substance use disorder that includes a pharmacologic intervention as part of a comprehensive substance abuse treatment plan with an ultimate goal of patient recovery with full social function.
- In the US, MAT has been demonstrated to be effective in the treatment of alcohol dependence with Food and Drug Administration approved drugs such as disulfiram, naltrexone and acamprostate; and opioid dependence with methadone, naltrexone and buprenorphine.

(b) As part of a comprehensive treatment program, MAT has been shown to:

- Improve survival
- Increase retention in treatment
- Decrease illicit opiate use
- Decrease hepatitis and HIV seroconversion
- Decrease criminal activities
- Increase employment
- Improve birth outcomes with perinatal addicts

(<http://www.dpt.samhsa.gov/medications/medsindex.aspx>)

(c) Research

More than 2 million adults are incarcerated in the United States, with approximately 12–15% having pre-incarceration histories of heroin addiction. While the rate of incarceration in the United States is estimated at four times higher than other industrialized nations such as Canada, England, Germany and France, rapid relapse to opioid (principally heroin) addiction following incarceration is a continuing, world-wide problem.

“A randomized clinical trial of methadone maintenance for prisoners: findings at 6 months post-release”
Michael S. Gordon, Timothy W. Kinlock, Robert P. Schwartz, and Kevin E. O’Grady

Abstract

Aims—This study examined the effectiveness of methadone maintenance initiated prior to or just after release from prison at 6 months post-release.

Design —A three-group randomized controlled trial

Findings

- Counseling + methadone participants were significantly more likely than both counseling only and counseling + transfer participants to be retained in drug abuse treatment (P =0.0001)
- Significantly less likely to have an opioid-positive urine specimen compared to counseling only participants (P = 0.002).
- Furthermore, counseling + methadone participants reported significantly fewer days of involvement in self-reported heroin use and criminal activity than counseling only participants.

Conclusions —Methadone maintenance, initiated prior to or immediately after release from prison, increases treatment entry and reduces heroin use at 6 months post-release compared to counseling only. This intervention may be able to fill an urgent treatment need for prisoners with heroin addiction histories.

Reference: *Addiction*. 2008 August ; 103(8): 1333–1342.

(d) Medications for Alcohol Use Disorder

- Naltrexone (ReVia®, Vivitrol®, Depade®) - reduces cravings for alcohol.
- Disulfiram (Antabuse®) - causes a very unpleasant reaction (e.g., aggressive vomiting) when a person drinks even a tiny amount of alcohol. This is a form of aversion therapy. A patient must take disulfiram daily until they're able to establish permanent self-control.
- Acamprosate Calcium (Campral®) – reduces cravings for alcohol.

(e) Medications for Opioid Use Disorder

- Methadone - methadone acts chemically on the brain’s receptors for opiate drugs. It fills these receptors, relieving the need for other opiate drugs.
- Buprenorphine (Suboxone® and Subutex®) - same effect as methadone, but is different in some ways. Suboxone is a combination of buprenorphine and naloxone (a compound that, if injected, blocks the effects of pain-killing opiates). Suboxone is a very safe drug, with minimal risk of overdose. An optimal dose can be achieved in a very short period of time: Suboxone usually takes

less than one week, whereas methadone dosage needs to be increased slowly and carefully over a longer period of time. Suboxone won't be sufficient for anyone using larger opiate doses, however, because it has no further benefit beyond a certain dosage.

- Naltrexone - reverses an opiate overdose when used intravenously

<http://www.dpt.samhsa.gov/medications/medsindex.aspx>

(f) Medication for Withdrawal Management - detox

(g) Medications for Nicotine and Tobacco Use Disorder

- Nicotine replacement systems (NRS) are well known to everyone and include patches, gum, oral inhalers and lozenges. These contain nicotine and are designed to minimize withdrawal symptoms. They can even be used in combination, in pregnancy, in young people ages 12 to 17 and in people who have heart disease.
- Bupropion (Zyban) was initially introduced as an antidepressant, but has been shown to reduce cravings and some of the discomfort of withdrawal. Bupropion can be used together with any of the NRS applications.
- Varenicline (Chantix) is an oral tablet that works by reducing the craving for nicotine.

B. Opioid Maintenance Treatment (OMT) (Opioid Treatment Programs OTP, in *The ASAM Criteria*, 2013)

1. Brief History and Attitudes

- The use of opioids as a maintenance pharmacotherapy began with the use of methadone by Dr. Vincent Dole and Marie Nyswander in the 1960s (Dole & Nyswander, 1965)
- Agents to reduce the desire to use illicit opioids - OTP used by 330,000 of the estimated two million opioid-addicted persons in USA in 2010 – Methadone is a synthetic opioid, long-acting analgesic for moderately severe to severe pain. half-life is 24 hours; long duration of action and once-a-day dosing. All are opioid agonists, but buprenorphine is also an opioid antagonist as the dose increases. (Payte, Zweben and Martin, Principles of Addiction Medicine 2014)
- Negative attitudes toward OTP common since 1960s among physicians, other treatment staff, patients and the general public (Payte, Zweben and Martin, Principles of Addiction Medicine 2014)
- These attitudes often stem from the perception that methadone treatment is “just substituting one addicting drug for another.”
- Rather than a simple substitution or replacement for illicit opioids, OTP involves a stabilization or correction of a possible lesion or defect in the endogenous opioid system (Dole, 1988; Goldstein, 1991)
- OTP currently viewed as treatment of a chronic medical disorder, with the goal of achieving control of the heroin addiction and avoiding the ravages if the untreated disease (Hser, Hoffman et al., 2001)

2. Opioid Treatment Services (OTS)

The ASAM Criteria (2013) has an updated opioid treatment section to incorporate new advances, named Opioid Treatment Services (addressing opioid antagonist pharmacotherapy in addition to opioid agonist pharmacotherapy).

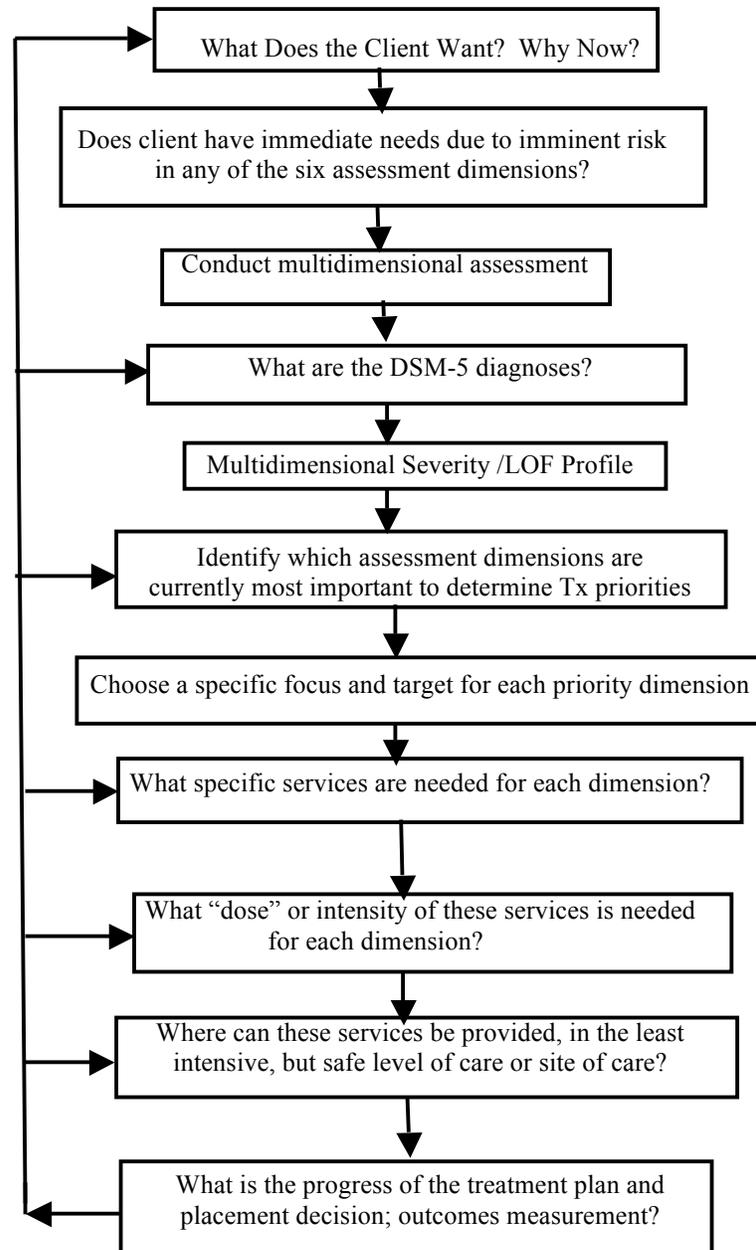
Previous editions and supplements of ASAM's criteria have described care offered in what this edition is naming Opioid Treatment Programs (utilizing methadone to treat opioid use disorder in Level 1 and previously called Opioid Maintenance Therapy, OMT.) The ASAM Criteria, Third Edition, is the first to address the growing use of office-based opioid treatment, utilizing buprenorphine products to treat opioid addiction.

C. How to Organize Assessment Data to Focus Treatment

Assessment of Biopsychosocial Severity and Function (*The ASAM Criteria* 2013, pp 43-53)

The common language of six ASAM Criteria dimensions determine needs/strengths in behavioral health services:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment



(*The ASAM Criteria* 2013, p 124)

D. Continued Service and Discharge Criteria (*The ASAM Criteria* 2013, pp 299-306)

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

Continued Service Criteria: It is appropriate to retain the patient at the present level of care if:

1. The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;
or
2. The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;
and/or
3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the patient's new problems can be addressed effectively.

To document and communicate the patient's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the patient's existing or new problem(s), the patient should continue in treatment at the present level of care. If not, refer the Discharge/Transfer Criteria, below.

Discharge/Transfer Criteria: It is appropriate to transfer or discharge the patient from the present level of care if he or she meets the following criteria:

1. The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;
or
2. The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;
or
3. The patient has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;
or
4. The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the patient's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the patient should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

E. Medication Treatment Adherence Problems – Differential Diagnosis and What to Do About It

It is important to diagnose why the person does not adhere to medication, otherwise the strategy may be counterproductive:

1. Cognitive – (a) client had a bad side effect or felt meds have not worked before and so won't take medication anymore – treat the fear of side effects and/or the lack of confidence in medication.

- (b) readiness to change issues – client not ready to accept medication as necessary for an illness which s/he may accept or about which is still ambivalent – motivational enhancement, stages of change work.
 - (c) wants to use natural substances rather than psychotropic medication.
2. Cultural – believes the medication is dangerous from his/her cultural perspective – get a bi-cultural outreach worker.
 3. Unconsciously non-adherent; somatic complaints; sick role; characterological; the more the therapist is involved, the more it shows they care and the more the sick role pays off; love Assertive Community Treatment (ACT) for example, because the more you go to their home to count pills, the more they are non-compliant to keep you coming back.
 4. Drug addicted – overusing pills due to an addiction.
 5. Psychotic – delusional – maintain the relationship and don't struggle over the diagnosis; ACT is appropriate in such situations.
 6. Malingering external incentives for the behavior e.g., keep getting workers compensation.
 7. Recovery Environment problems – Insufficient funds to pay for medication and/or transportation and/or childcare to keep appointments for medication monitoring

F. Gathering Data on Policy and Payment Barriers (*The ASAM Criteria* 2013, p 126)

- ⤴ Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or in adequate meeting of a client's needs can be a data point that sets the foundation for strategic planning and change
- ⤴ Finding efficient ways to gather data as it happens in daily care can provide hope and direction for change

PLACEMENT SUMMARY

Level of Care/Service Indicated - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter	
Level of Care/Service Received - ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service	
Reason for Difference - Circle only one number -- 1. Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level; 5. Service available, but no payment source; 6. Geographic accessibility; 7. Family responsibility; 8. Language; 9. Not applicable; 10. Not listed (Specify):	
Anticipated Outcome If Service Cannot Be Provided – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify):	

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