New Jersey Drug Court

SETON HALL LAW SCHOOL
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NEW JERSEY DRUG COURT PROGRAM DATA

The most current data reports from the Administrative Office of the Courts, dated November 13, 2017 state

- More than 22,761 defendants have entered New Jersey's adult drug court program since the statewide program began on 4/1/02;
- The statewide rate of retention after one year in the program is 81.6% percent;
- The cumulative rate of program retention after twelve years of operation is 51.3 percent;
- 99 percent of program participants were prison-bound, meaning that they would have been sentenced to a state prison term were it not for the drug court program;

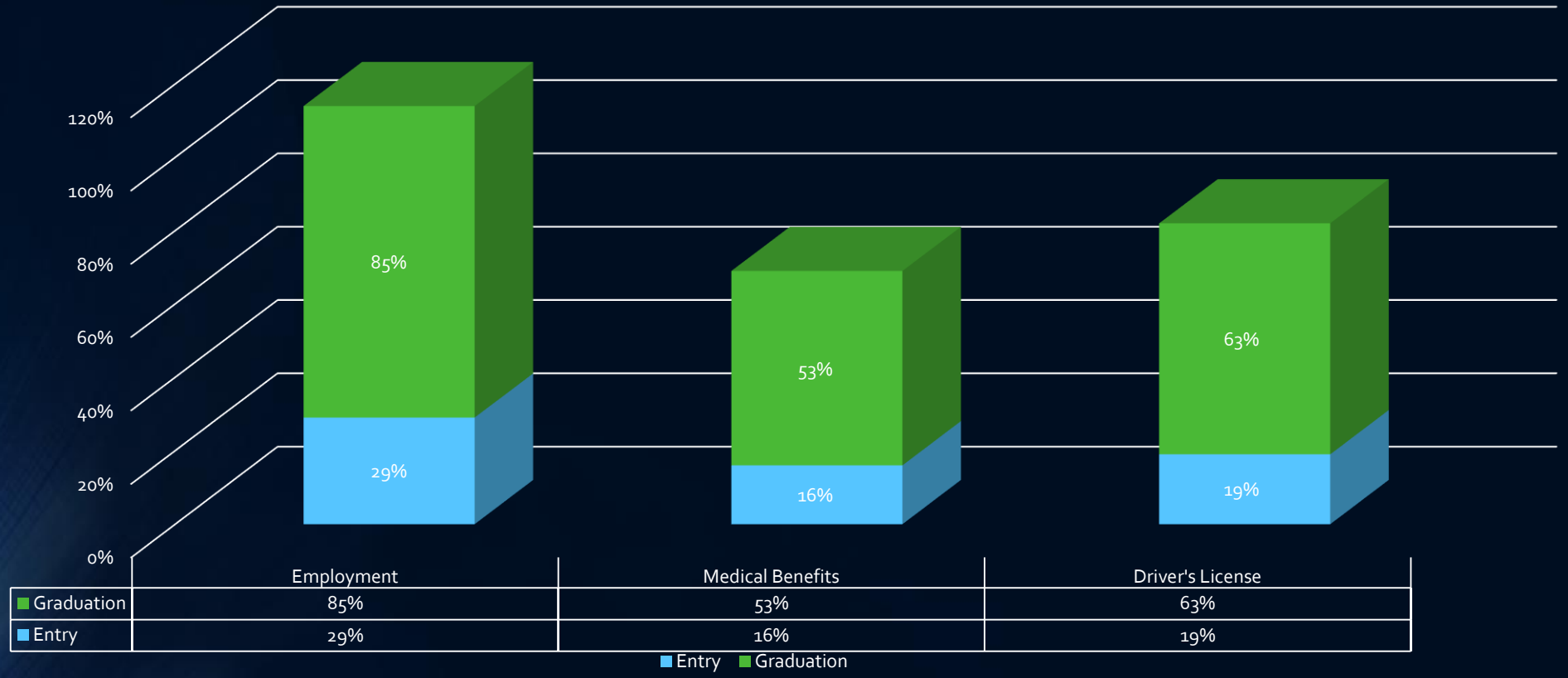
NEW JERSEY DRUG COURT PROGRAM DATA

- Since 4/1/02, 602 babies were born drug free from previously addicted participant mothers;
- Since 4/1/02, 197 participant parents have regained custody of their minor children due to their successful participation in the drug court program;
- As of 11/1/17, there were 6,416 program participants and 5,076 program graduates.

NEW JERSEY DRUG COURT GRADUATES outcome DATA

- 30 percent of all graduates improved their level of education or vocational/employment skills while in the drug court program
- Over 12.75 million dollars in fine payments have been collected from drug court participants
- The lives of 3,586 minor children were improved by their parent's participation in and graduation from, the drug court program.

Drug court graduation outcome



Recidivism of Drug Court and DOC

53 

DOC rearrest rate

37 

DOC reconviction rate

29 

DOC reincarceration rate

18 

DC rearrest rate

7 

DC reconviction rate

3 

DC reincarceration rate

January 2018 the following Medication Assisted Treatment was approved by the New Jersey Judiciary.

Drug Court MAT Policy

New Jersey Adult Drug Court
Medication-Assisted Treatment
Protocols and Procedures for Drug Court Teams

I. Background and Definition

On August 10, 2015, Governor Christie signed into law S2381 as P.L. 2015, c.93. The act took effect immediately and amended N.J.S.A. 2C:35-14 and creating N.J.S.A. 2C:45-5 to permit the use of medication-assisted treatment by Drug Court participants under specific conditions stipulated within this legislation. The term "medication-assisted treatment (MAT)" is herein defined as "the use of any medications approved by the federal Food and Drug Administration (FDA) to treat substance use disorders, including extended-release naltrexone, methadone, and buprenorphine, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders".

N.J.S.A. 2C:35-14f(7) and 2C:45-5

Drug Court MAT Policy

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II. Elements of the MAT Law

A. Residential or ambulatory treatment at a facility licensed by the Department of Human Services (DHS) and approved by the Division of Mental Health and Addictions Services (DMHAS) may include the use of medication-assisted treatment.

B. A positive drug or alcohol test shall only constitute a violation for a person using medication-assisted treatment as defined in paragraph (7) of subsection f of this law if the positive test is unrelated to the person's medication-assisted treatment.

C. Concerning violation for failure to complete the required treatment program successfully, use of the medication-assisted treatment shall not be the basis to constitute a failure to complete the treatment program successfully.

N.J.S.A. 2C:35-14a(8)
N.J.S.A. 2C:35-14e, 2C:35-14k(1), 2C:35-14l
N.J.S.A. 2C:35-14f(7) and 2c:45-5

Drug Court MAT Policy

continued…

III. Protocols and Procedures

A. The team must obtain from the physician prescribing the MAT an initial assessment and plan, including but not limited to, the following:
   1. Health risks identified and how each will be addressed;
   2. The medication selected and rationale for prescribing it, and expected impact of pharmacotherapy; and
   3. The informed consent and education provided to the client about the medication-assisted treatment options, his/ her/ their health conditions and any potential interactions or complications that may occur in regards to the planned medication-assisted treatment.

B. Teams must request clinical updates, which include, but are not limited to, progress in psychosocial treatment (counseling), medication compliance, dosage adjustments, and drug screen results.

Drug Court MAT Policy

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C. Drug Court clients may resume the use of MAT following court sanctions yielding brief jail time or after discontinuation as long as clinical justification is provided by the prescribing physician.
D. If it is medically and clinically indicated, while serving a jail sanction arrangements may be made to maintain Drug Court clients on their MAT. When possible, this can be achieved by the Drug Court coordinator assisting the Opioid Treatment Provider (OTP) with coordinating dosing services at the jail.
E. Participants may successfully complete treatment, obtain phase promotions and successfully complete Drug Court while on an MAT.
F. Clients may titrate off MAT at any time they desire or as clinically indicated.

Drug Court MAT Policy

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IV. Special Considerations

A. Drug testing and diversion—Drug testing will need to include methadone/buprenorphine for MAT clients and other participants to verify that MAT clients are taking their MAT and not diverting. For clients suspected of diversion, the courts may communicate with methadone clinics to restrict the number of take-home bottles allotted and with buprenorphine prescribers to restrict the amount of Suboxone per refill.

B. Safety of participants' children—Methadone is a powerful opiate agonist and can be fatal. When conducting a home visit, probation officers may want to ask participants if "take-home" dosages are safely stored or in a locked cabinet.

Drug Court MAT Policy

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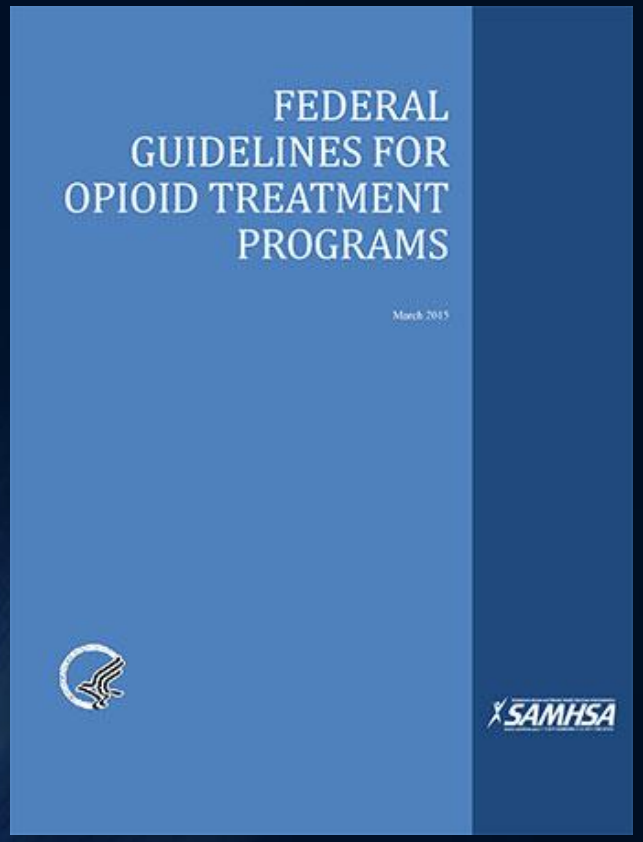
C. Teams may need to establish a relationship and communication with physicians who prescribe MAT and who are out of the drug court network.
D. Communication with treatment providers-- Teams will need to direct their providers that the team must be advised in advance when a participant is being recommended to use MAT for the sake of participant compliance with special probation mandates.

MAT Utilization in Drug Court

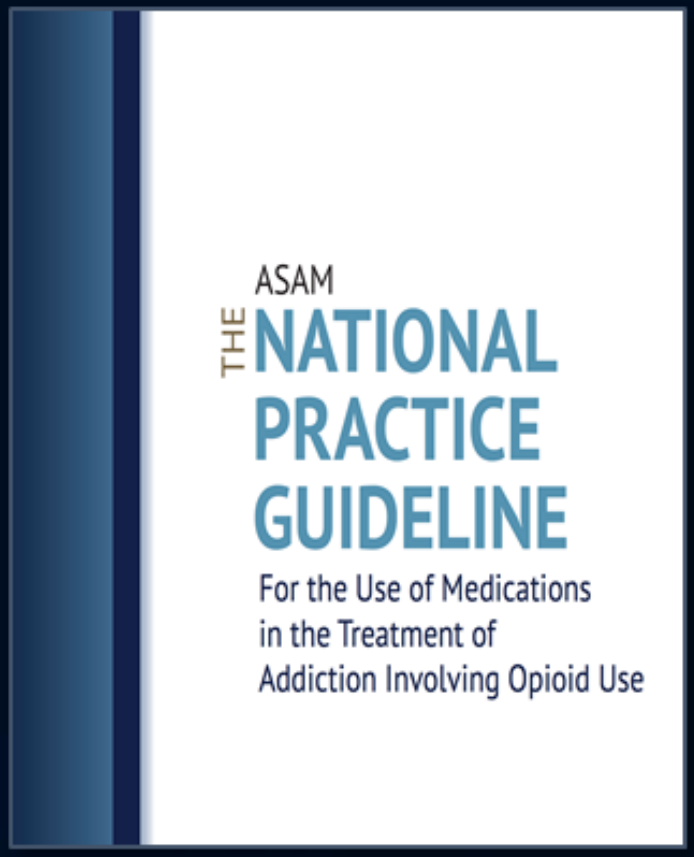
Fiscal Year	# of clients	Methadone Utilization	Buprenorphine Utilization	Vivitrol Utilization	Suboxone Utilization
2016	64	28	0	34	2
2017	165	47	4	116	0
2018	148	38	5	100	0

http://store.samhsa.gov/shin/content/SMA16-4892PG/SMA16-4892PG.pdf

SAMHSA and ASAM Best Practice References



March 2015



May 2015

SAMHSA's Definition of MAT

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.

http://dpt.samhsa.gov/medications/medsindex.aspx

Medication Assisted Treatment (MAT)

What MAT Is…

- Adjunct to treatment at any level
- Various medications
- Research and development in process

What MAT Is Not…

- Treatment
- A level of care
- Without controversy

MAT Clinical Justification for Drug Court

The team must obtain from the physician prescribing the MAT an initial assessment and plan, including but not limited to, the following:

- Health risks identified and how each will be addressed;
- The medication selected and rationale for prescribing it, and expected impact of pharmacotherapy;

  and

- The informed consent and education provided the client about the medication-assisted treatment options, his/ her/ their health conditions and any potential interactions or complications that may occur in regards to the planned medication-assisted treatment.

Extended Release Injectable Naltrexone

- Alcohol Use Disorder and Opioid Use Disorder
- Route of Administration– intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional
- Who may prescribe or dispense– any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff
- Potential for abuse and diversion– no
- Naltrexone hydrochloride tablets (50 mg) are also available for daily dosing

SAMHSA Pocket Guide Medication-Assisted Treatment of Opioid Use Disorder http://store.samhsa.gov/shin/content/SMA16-4892PG/SMA16-4892PG.pdf

Vivitrol for Opioid Use Disorders

- Full opiate antagonist, 30 day injection, time released
- Vivitrol (half-life 10-14 days)
- Withdrawal management as maintenance, address cravings to deter use and prevent impulsive use
- No psychoactive effects
- Blocks the high, attempts to over-ride the block can be fatal
- Contraindicated in patients who have hepatic failure, esophageal variceal disease, HIV, hepatitis, major depression or other serious psychiatric conditions; off label use pregnant
- Clients must be **highly** motivated
- Approved October 12, 2010

Methadone

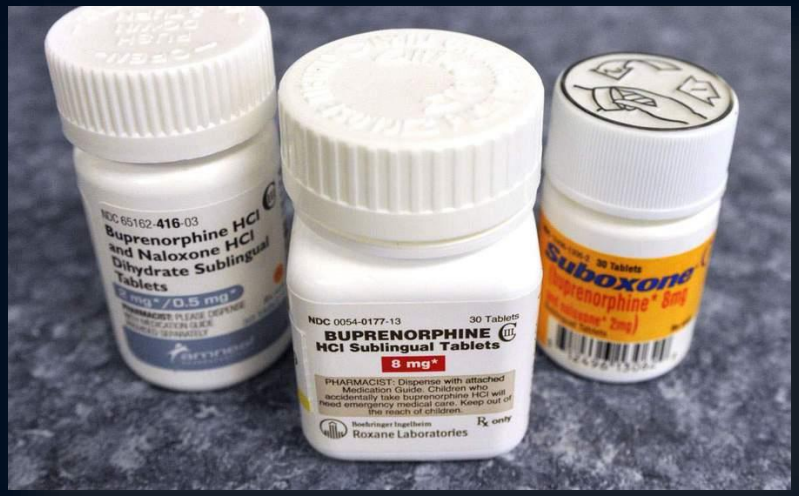
- Full agonist
- Synthetic opioid
- No Ceiling Effect
- Available for opiate dependence only in clinics, counseling is not required
- Half-life is up to 59 hours (compare to Heroin at 2-4 hours)
- Detection time 3-6 days
- Analgesia, antitussive, respiratory depression, euphoria, stupor, “nodding”, pupil constriction; constipation; histamine release
- Tolerance, withdrawal (acute & protracted), non-exact cross-tolerance at mu receptors thus risk of overdose

Methadone
Pharmacological Category– Opioid Agonist

Patients starting methadone should be educated about the risk of overdose during induction onto methadone, if relapse occurs, or substances such as benzodiazepines or alcohol are consumed. During induction, a dose that seems initially inadequate can be toxic a few days later because of accumulation in body tissues.

SAMHSA Pocket Guide Medication-Assisted Treatment of Opioid Use Disorder http://store.samhsa.gov/shin/content/SMA16-4892PG/SMA16-4892PG.pdf

Buprenorphine



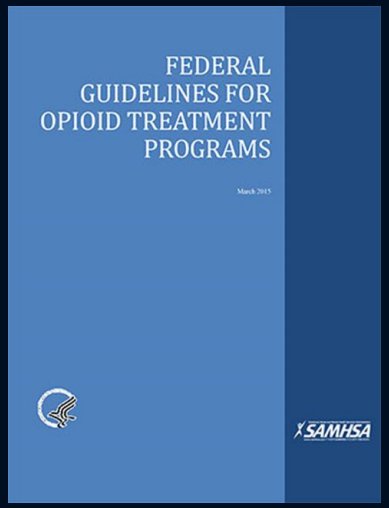
- Partial agonist
- Synthetic opioid
- Absorbed sublingually—ineffective if just swallowed
- Safety: Ceiling Effect at 32mg
- Minimal subjective effects (i.e.: sedation)
- Available for use by certified physicians in office settings
- Counseling is required
- Half-life is 24-60 hours (compare to Heroin 2-4 hours)
- Detection time 3 days
- Withdrawal management as detox or maintenance, address cravings to deter use
- Unknown impact on brain chemistry restoration with maintenance

Buprenorphine

- Route of Administration– oral tablet or film is dissolved under the tongue
- Who may prescribe or dispense– physicians must have board certification in addiction medicine or addiction psychiatry and/or complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.
- Potential for abuse and diversion– yes

SAMHSA Pocket Guide Medication-Assisted Treatment of Opioid Use Disorder http://store.samhsa.gov/shin/content/SMA16-4892PG/SMA16-4892PG.pdf

Federal Guidelines for Opioid Treatment Programs



- The patient must be "currently addicted to an opioid drug" using suggested medical criteria as the DSM and have become addicted at least 1 year prior.
- A physician can waive the 1 year requirement for inmates being released, pregnant patients, and previously treated patients (note: there is no waiver to the "currently addicted" requirement).
- "All persons admitted for maintenance therapy must be "currently addicted to an opioid drug". (page 22)

Federal Guidelines for Opioid Treatment Programs
continued

- Patients must sign an informed consent with the provider to include: "all relevant facts concerning the use of the opioid drug are clearly and adequately explained" and explain risk of relapse following detox (page 24)
- An Opioid Treatment Provider (OTP) shall not admit a patient for more than 2 detox treatment episodes in one year. (page 22)
- An OTP may readmit a patient within 30 days without repeating the initial assessment. (page 26)

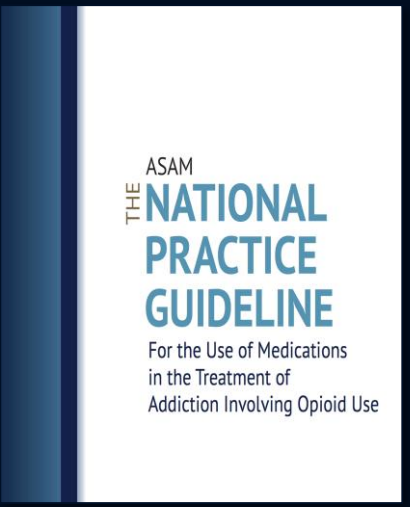
Federal Guidelines for Opioid Treatment Programs *continued*

- The provider's assessment and plan should summarize the medication selected and rationale for prescribing it. (page 30)
- Patients unsuccessfully treated with methadone or buprenorphine and continue to use illicit opioids, benzodiazepines and alcohol to the extent of increased overdose risk should be considered for Naltrexone. (page 34)
- Unless clinically indicated there should be no limits on duration or dosage. (page 35)

Federal Guidelines for Opioid Treatment Programs
continued

- Patients with co-occurring pain should receive treatment from both pain management and addiction medicine specialists. (page 38)
- Programs develop procedures to coordinate and communicate with the criminal justice system and advocate for the continuous treatment of patients who are incarcerated. (page 41)
- Within a few days of discharge from an MAT program, a client who wants to use can be readmitted without having to use again. (page 73)

The ASAM National Practice Guideline



- The use of benzodiazepines and other sedative hypnotics may be reason to suspend agonist (cites as methadone or buprenorphine) treatment. (page 13)
- Counseling is recommended with all forms of MAT. Efficacy of naltrexone without counseling has not been established. (pages 17, 19, & 20)
- Patients who discontinue use of methadone, buprenorphine, or naltrexone then resume opioid use are at increased risk associated with overdose, and especially the increased risk of death. (pages 18 – 20)

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