

Results from Survey on Medication Assisted Treatment in the Criminal Justice System:
A Nationally Representative Survey of Drug Courts

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Medication Assisted Treatment (MAT) in the Drug Courts

Respondent Demographics (tables 1-5): The majority of respondents (67%) were drug-court coordinators followed by administrators (18%). Percentages for other drug court roles were less than five percent. Four-fifths (81%) of respondents had worked in their respective profession for more than 5 years; 20% for more than 20 years. More than half (57%) of the respondents had worked in drug courts for at least 5 years. The most frequently endorsed professional disciplines (within the drug court) were drug treatment professional (39%), social worker (30%) and counselor (12%); 10% described their discipline as lawyer or judge. Almost two-fifths (38%) had a bachelor's degree and 52% had an advanced degree (40% Masters, 9% JD, 3% PhD).

Drug Court Statistics (tables 6, 7): Aside from South Dakota, Montana, and New Jersey surveys were received from every state plus Puerto Rico and Washington D.C. Thirty-two percent of our respondents were urban courts, 37% suburban, and 31% rural. Twenty-nine percent of the courts have 25 or fewer clients, 27% have 26-50, 14% have 51 to 100, and 29% have more than 100 clients.

Characteristics of Drug Court Participants (tables 8,9): Almost half (45%) of the drug courts estimated that more than 20% of their clients were addicted to opioids; 20% estimated that 10-20% of their clients were addicted to opioids, and 30% estimated that 1-10% of their clients were addicted to opioids; Only 1% reported that none of their clients were addicted to opioids. Prescription opioids were more likely than heroin to be cited as the primary opioid problem (61% vs. 32%; 6% endorsed "don't know").

Prevalence of MAT (table 10): We asked the courts to estimate the percentage of opioid-addicted clients that received specific medications. Answer choices ranged from 0 to 100% with a "don't know" option. For the purposes of this analysis, we interpreted "don't know" as not zero, meaning that at least 1 or more drug court clients had received the indicated medication (although the respondent was unable to estimate the percent of clients using the indicated medication). Using this convention, the percentage of drug courts providing medications for the treatment of opioid dependence were: some type of MAT 67%; methadone and/or buprenorphine maintenance 52%; oral naltrexone 23%; monthly naltrexone injection (Vivitrol) 18%; methadone maintenance 32%; and buprenorphine 44%.

Circumstances under which agonist therapy is offered (table 11): Circumstances under which agonist therapy (buprenorphine or methadone) was available varied widely. Across all categories buprenorphine was more widely available than methadone. For example, for clients who were already maintained on agonist therapy 22% of drug courts offered methadone and 32% offered buprenorphine (a total of 40% offered any agonist medication). For opioid-addicted pregnant clients not already receiving agonist medication, approximately three-quarters do not receive either buprenorphine or methadone. Fifty percent of courts surveyed did not permit agonist medication under any circumstances, 47% methadone and 42% buprenorphine.

Attitudes about MAT (table 12): While drug court personnel were generally more likely to endorse favorable/accurate views toward agonist therapy than disagree with such views, the most widely selected choice for the large majority of attitudinal questions – more so for buprenorphine than for methadone - was “uncertain.” For example, while 47% of respondents agree that “buprenorphine helps reduce relapse,” 48% answered “uncertain.” By comparison, 44% agree that methadone helps reduce relapse, and 35% were uncertain. Seventeen and 9% of respondents agree that the use of methadone and buprenorphine, respectively, “rewards criminals for being drug users;” 51% of respondents disagreed with this item (for both drugs). Examples where respondents were more likely to endorse an inaccurate or biased view toward agonist therapy included the item that methadone “prolongs addiction” (36% agree and 23% disagree) and that it should be used as a maintenance therapy (30% agree and 36% disagree). Respondents were also more likely to disagree than agree with the item that agonist therapy was more likely to retain patients in treatment than non-pharmacological approaches.

Reasons Buprenorphine or Methadone might not be offered (table 13): Frequently endorsed obstacles to agonist medication were drug court policy (buprenorphine 38%; methadone 56%), cost (buprenorphine 43%; methadone 27%), lack of recommendation or availability from the treatment provider (buprenorphine 32%; methadone 52%), and that clients were detoxed before they enter supervision (buprenorphine 40%; methadone 43%). “Don’t know” comprised a sizeable minority of answers for many questions in both the buprenorphine and methadone sections.

Introducing or Expanding the use of Agonist Therapy (tables 14, 15): Fifty-four percent of respondents answered that it would be possible to introduce or expand the use of agonist medication in their courts “if evidence were available that methadone or buprenorphine improved outcomes for drug court clients.”

Medications for Alcoholism (table 16): Fifty percent of the surveyed courts offered MAT for their alcohol-addicted participants; disulfiram (Antabuse) 42%, oral naltrexone 40%, injectable naltrexone (Vivitrol) 29%, and acomprosate (Campral) 33%.

Buprenorphine and Methadone in the Criminal Justice System

1. Professional role in the drug court? N=93

	Response Percent
Administrator	18%
Coordinator	67%
Prosecutor	0%
Judge	4%
Defense	0%
Probation	5%
Treatment	4%
Other	1%

2. Years of experience in this field? N=93

	Response Percent
0-1 year	1%
1-5 years	17%
5-10 years	30%
10-20 years	31%
More than 20 years	20%

3. Years of experience in drug courts? N=93

	Response Percent
0-1 year	2%
1-5 years	41%
5-10 years	38%
10-20 years	19%
More than 20 years	0%

4. Professional discipline. N=93

	Response Percent
Social Worker	30%
Counselor	12%
Lawyer	6%
Drug treatment professional	39%
Judge	4%
Other	9%

5. Highest academic degree attained? N=93

	Response Percent
G.E.D.	1%
High School Diploma	5%
Associate's Degree	4%
Bachelor's Degree	38%
Master's Degree	40%
J.D.	9%
Ph.D.	3%

6. In what state is your program?* N=93

Answer Options	Response Percent	Response Count	Answer Options	Response Percent	Response Count
AL	1%	1	MT	0%	0
AK	2%	2	NE	1%	1
AZ	2%	2	NV	2%	2
AR	2%	2	NH	1%	1
CA	2%	2	NJ	0%	0
CO	1%	1	NM	2%	2
CT	2%	2	NY	4%	4
DC	1%	1	NC	6%	6
DE	2%	2	ND	1%	1
FL	1%	1	OH	1%	1
GA	1%	1	OK	1%	1
HI	1%	1	OR	2%	2
ID	2%	2	PA	4%	4
IL	1%	1	PR	1%	1
IN	3%	3	RI	1%	1
IA	1%	1	SC	2%	2
KS	2%	2	SD	0%	0
KY	6%	6	TN	1%	1
LA	1%	1	TX	2%	2
ME	2%	2	UT	3%	3
MD	2%	2	VT	2%	2
MA	1%	1	VA	4%	4
MI	1%	1	WA	1%	1
MN	3%	3	WV	1%	1
MS	2%	2	WI	1%	1
MO	3%	3	WY	1%	1

***New Jersey declined to participate in this survey. No responses were recorded from South Dakota or Montana**

7. Please estimate the total number of drug court participants currently enrolled in your program. N=93

	Response Percent
0-10	6%
11-25	23%
26-50	27%
51-100	14%
101-200	18%
201-300	4%
301-400	4%
Greater than 400	3%

8. Please estimate the proportion of people in your program who were addicted to opioids in calendar year 2010 (1/1/2010 - 12/31/2010). N=93

	Response Percent
None	1%
1% to 5%	18%
5% to 10%	12%
10% to 20%	20%
More than 20%	45%
Don't Know	3%

9. Primary opioid problem seen among your drug court participants? N=93

	Response Percent
Heroin	32%
OxyContin, Vicodin, or other prescription	61%
Don't Know	6%

10. Please estimate the percentage of your opioid addicted participants that received the following medications in 2010: N=93

Percentage	Any	None	5%	10%	15 to 95%*	100%	Don't know**
Naltrexone as a pill	23%	77	9	1	2	0	11
Naltrexone as a monthly injection (Vivitrol)	18%	82	4	0	2	1	11
Methadone maintenance	32%	68	13	5	9	0	5
Buprenorphine maintenance	44%	56	19	3	12	2	8
Counseling	95%	5	7	3	12	68	5
Opioid detox services (with or without use of medications)	60%	40	19	4	22	3	12
Other type of medication	46%	54	9	3	9	1	25
Any MAT	67%						
Agonist MAT	52%						

*Respondents were offered the opportunity to choose the percentage in 5% increments from 0 to 100%. Because there were few responses between 15 and 95% we collapsed these columns for ease of reading.

**"Don't know" is interpreted to mean that the medication is available to an unknown number of recipients.

11. Under what circumstances are methadone or buprenorphine offered for drug court participants in your program? (Check all that apply.) N=90

	Methadone	Buprenorphine	Any agonist
Tapered detox for clients who are currently in treatment with methadone or buprenorphine.	29%	36%	42%
For all clients who are already on methadone or buprenorphine.	22%	32%	40%
For induction and maintenance for clients who have been using illicit opioids.	18%	30%	34%
For pregnant clients currently in treatment with methadone or buprenorphine.	18%	24%	28%
For pregnant clients who have been using illicit opioids.	14%	22%	26%
Other circumstances	3%	3%	3%
Not permitted under any circumstances	47%	42%	50%

12. Please indicate if you agree, disagree, or are uncertain about the following statements:	Buprenorphine N=90			Methadone N=88		
	Agree	Uncertain	Disagree	Agree	Uncertain	Disagree
Reduces relapse	47%	48%	6%	44%	35%	20%
Can help reduce crime and re-incarceration.	41%	51%	8%	41%	40%	19%
Rewards criminals for being drug users.	9%	40%	51%	17%	32%	51%
Prolongs addiction.	22%	48%	30%	36%	41%	23%
Should be used to maintain clients who are already opioid addicted.	33%	44%	22%	30%	34%	36%
More effective than non-pharmacological approaches in retaining patients in treatment.	18%	60%	22%	12%	56%	32%
Interferes with the ability to drive a car.	4%	61%	34%	12%	61%	26%
Reduces or blocks the effects of heroin.	43%	53%	3%	47%	41%	12%

13. Please help us understand why buprenorphine or methadone may not be offered, or may be offered in a limited way in your program.	Buprenorphine N=90			Methadone N=88		
	Yes	No	Don't Know	Yes	No	Don't Know
Cost is prohibitive/insufficient funding	43%	21%	36%	27%	40%	33%
Risk of diversion	29%	30%	41%	36%	30%	34%
Drug court policy not to permit its use	38%	47%	16%	56%	34%	10%
Drug treatment provider does not recommend or provide it	32%	46%	22%	52%	33%	15%
Clients are detoxed before they enter supervision	40%	49%	11%	43%	50%	7%
Not beneficial to clients	14%	46%	40%	23%	41%	36%
Opposition from prosecutor	21%	43%	36%	30%	40%	31%
Opposition from judge	21%	53%	26%	32%	44%	24%
Opposition from state/county/municipal government	6%	53%	41%	15%	48%	38%
Lack of local providers	33%	34%	32%	28%	54%	17%
Opioid addiction is not a common problem among drug court clients	17%	72%	11%	12%	78%	9%
Not familiar with this medication	26%	67%	8%	16%	75%	9%

14. If evidence were available that methadone or buprenorphine improved outcomes for drug court participants, would it be possible to introduce or expand their use in your program? N=88

	Response Percent
Yes	54%
No	14%
Don't know	32%

15. How much of a decrease in re-incarceration and/or relapse for opioid users would have to be demonstrated in order to introduce or expand the use of methadone or buprenorphine in your program? N=86

	Response Percent
1%-5%	2%
5%-10%	7%
10%-20%	8%
20%-40%	12%
Greater than 40%	22%
I don't know	49%

16. What medications are available for your participants for alcoholism? N=86

	Yes
Naltrexone as a pill	40%
Naltrexone as a monthly injection (Vivitrol)	29%
Disulfiram (Antabuse)	42%
Acomprosate (Campral)	33%
ANY Medication for alcoholism	50%