CALIFORNIA HEALTH POLICY STRATEGIES, L.L.C.

Policy Brief

Collaborative Courts and Medication-Assisted Treatment in California

October 2018

Executive Summary

This policy brief provides an overview of Medication-Assisted Treatment (MAT) in California's collaborative courts. MAT is the leading evidence-based method for treating addiction that involves both medication and behavioral health interventions. Medications for opioid use disorder include three pharmacologic agents approved by the Food and Drug Administration: methadone, buprenorphine and naltrexone. Substantial evidence demonstrates the benefits of MAT across a range of health and societal outcomes, including improved retention in treatment, lower rates of illicit opioid use, reduced recidivism, and significant reductions in all-cause and overdose mortality. Provision of methadone and buprenorphine in custody settings has been shown to dramatically decrease the risk of overdose death after release. California's collaborative courts "combine judicial supervision with rehabilitation services that are rigorously monitored and focused on recovery to reduce recidivism and improve offender outcome."[1]

Our report focuses on collaborative courts that supervise adults. These include:

- Adult Drug Courts,
- "DUI/DWI" (driving under the influence or driving while impaired) Courts,
- Family Dependency Drug Courts,
- Federal Reentry Courts,
- Homeless Courts,
- Mental Health Courts,
- Reentry Courts, and
- Veterans Treatment Courts.[2]

The brief finds that some courts are successfully including MAT as a treatment option for their clients. However, many courts have not yet done so for a variety of reasons, including lack of information, inadequate resources, contrary treatment philosophy, and other barriers. Some treatment providers, public safety professionals, and clients are skeptical of MAT because they believe it is ineffective or

[1] http://www.courts.ca.gov/programs-collabjustice.htm

[2] See Appendix F for descriptions

"substituting one drug with another." Many professionals are accustomed to and more comfortable with an abstinent-based model of treatment and are unfamiliar with or skeptical of MAT's medical efficacy. In some counties, particularly in rural areas, courts and treatment providers are interested in developing MAT treatment options for their clients, but they but do not have adequate resources to do so. In California, collaborative court clients are most often users of methamphetamines, a drug addiction for which there is not yet an FDA approved medication available for treatment.

California Health Policy Strategies (CalHPS) has found that courts and counties which have adopted MAT as a treatment option have had to undergo significant "cultural change" before embracing MAT. This included buy-in from high-level professionals such as judges, sheriffs, district attorneys, and county supervisors. Many of these courts and counties also established clear protocols for connecting clients to substance use treatment programs that utilize MAT, benefitted from the hub-and-spoke model of medical treatment[3], and cultivated strong relationships between court and treatment professionals. Together, these elements have contributed to the development of successful MAT programs.

There is compelling evidence supporting MAT and collaborative courts are increasingly interested in including MAT among their array of treatment options. To accelerate the pace of this trend, counties and courts will need to take concrete steps to connect collaborative court clients to MAT as a treatment option in the community and expand availability of MAT in California prisons and jails. Based on our findings, we offer the following recommendations:

- Disseminate additional information about MAT and how it can be integrated as a treatment option. This additional information can help to advise and assist collaborative courts, treatment providers, and law enforcement in developing local programs and protocols.
- Consider how MAT can be integrated in jails and the community. Integration of MAT in both jails and the community is critical to assuring continuity of care for justice-involved individuals who frequently move between these systems.
- Develop written MAT guidelines to delineate roles, responsibilities, and protocols that clarify processes and expectations. MAT guidelines can cultivate buy-in from skeptics, streamline processes, and ensure that clients have consistent, vetted options for treatment.

[3] California is implementing a "hub and spoke" model for MAT treatment, with approximately 19 hubs and 119 spokes throughout the state. "Hubs" are regional resources with a broad public health mission, including Narcotic Treatment Programs and Medication Units licensed by the Department of Health Care Services. "Spokes" provide ongoing care for patients and have access to dedicated MAT teams. Spokes can refer complex patients to the Hub in their region. Source: California Hub & Spoke System Frequently Asked Questions, California Department of Health Care Services https://www.dhcs.ca.gov/individuals/Documents/CA_Hub_and_Spoke_FAQ.pdf

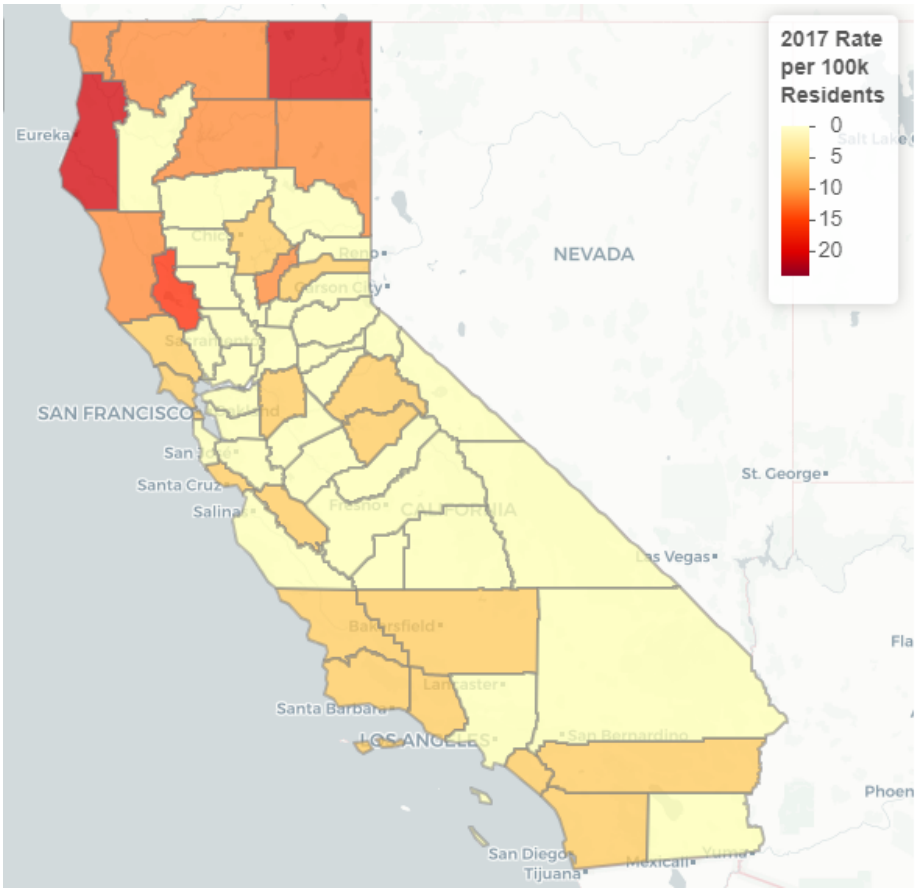
Table of Contents

Introduction

Opioid Overdose in California

Nationally, policymakers, medical professionals, courts, and substance use professionals are contending with a deadly opioid epidemic. California is not immune to this challenge. Opioid overdose deaths are present in nearly every California county (Figure 1)[4]. While the California's rates of opioid overdose deaths do not appear to have risen over the past 10 years, non-Heroin Opioid users' emergency department visits are increasing (Appendix A). Moreover, rates of death by Fentanyl overdose have increased sharply across the state (Figure 2), mirroring a concerning uptake in Fentanyl that has been observed in other states.

Figure 1: California Opioid Overdose Deaths, Preliminary 2017, Age-Adjusted Rate per 100,000 Residents[5]

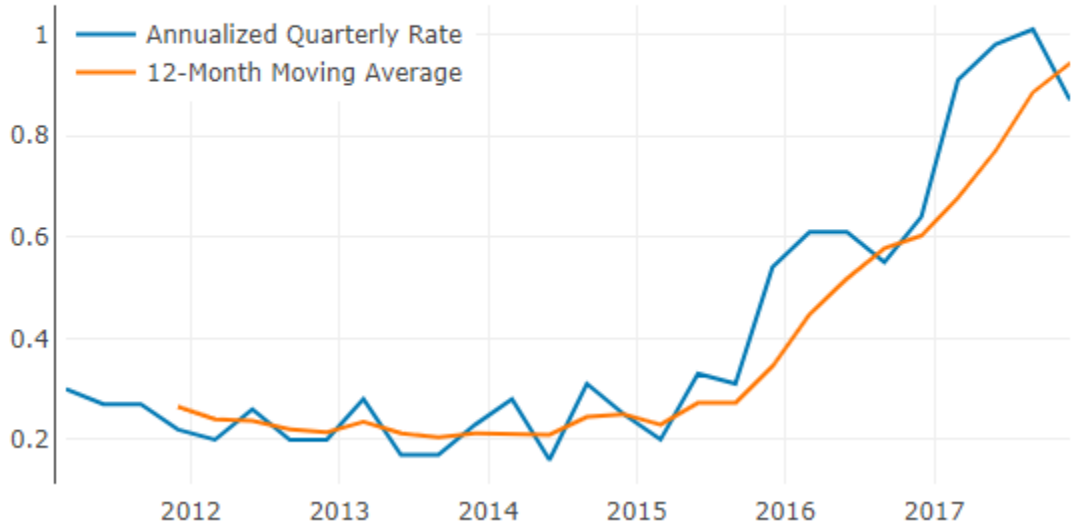


Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by California Department of Public Health, Safe and Active Communities Branch.

[4]No opioid deaths were reported in Alpine, Colusa, Glenn, Mono, Sierra, Tehama Counties in 2017.

[5]CDPH Vital Statistics Multiple Cause of Death Files https://discovery.cdph.ca.gov/CDIC/ODdash/
Prepared by: California Department of Public Health, Safe and Active Communities Branch. Note that age-adjusted rates across counties ensure that the differences between counties does not reflect differences in the age distributions across counties.

Figure 2: Fentanyl Overdose Deaths per 100,000 residents, 2017 [6]



Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by California Department of Public Health, Safe and Active Communities Branch.

County-level data in California indicates that opioid overdose deaths vary significantly across counties (Tables 1 and 2 in Appendix B). The highest rates of opioid overdose deaths are concentrated in California's rural, northern counties. Because their large size, the highest counts of opioid overdose deaths are in Los Angeles, San Diego, Orange, and Riverside, which see between 112 and 354 deaths annually since 2013.

Some counties have undergone notable changes in opioid overdose death rates over the past five years (Table 3 in Appendix B). Some of California's northern counties (Yuba, Modoc, Siskiyou, and Humboldt) have seen large upticks in opioid overdose deaths, with the sharpest increase in Yuba County where the age-adjusted death rate increased by 13 from 2013 to 2017. Other counties which experienced high rates of opioid overdose deaths in 2013 have seen reductions by 2017, most notably Plumas County where the age adjusted death rate fell by 29% over this period.

Overall, California's data indicates that opioid overuse is present across the state and increasing in some counties. Given this, it is necessary to better understand the best ways combat opioid overuse and to invest in the most effective strategies. Medication-Assisted Treatment, discussed in the next section, offers one way to do so.

[6] ibid

What is Medication-Assisted Treatment (MAT)?

Medication-Assisted Treatment (MAT) is a method of addressing substance use disorders that involves both medication and behavioral health interventions. MAT is primarily used to treat opioid, alcohol, and tobacco substance use disorders.[7] It is widely-accepted in the medical community.

Before MAT, most treatment programs and providers utilized abstinence-based models to address substance use disorders.[8] The recent increase in opioid overuse and failure of abstinence-based treatment approaches to reduce drug-related deaths, however, prompted increased interest in harm reduction strategies and an uptake of evidence-based treatment approaches.[9]

MAT has been employed for many years. Over the last decade, major health organizations and substance-addiction treatment programs have adopted and advocated for MAT (See Box 1).[10] Today, there is consensus in the medical community that MAT is a highly-effective form of treatment for substance use disorders. In this context, it should be noted that MAT is not always successful. As with any chronic, relapsing medical condition, many affected individuals who access even the most cutting edge and comprehensive treatment programs are not always successful. That said, MAT has higher success rate than other treatment options.

Experts also endorse MAT due to its societal benefits, such as MAT's capacity to reduce treatment costs and recidivism.[11] In a 2014 Information Bulletin, for instance, the Center for Medicare and Medicaid Services, the Center for Disease Control and Prevention, Substance Abuse and Mental Health Services, and the National Institutes of Health recommended MAT in part due to evidence that MAT offers "substantial cost savings."[12] (See details of savings in Box 2.) [13] In addition, multiple academic studies have shown that when justice-involved individuals have access to MAT, recidivism and re-incarceration

[7] https://www.samhsa.gov/treatment/substance-use-disorders
[8] https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone
[9] Ibid
[10] http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf; http://nasadad.org/wp-content/uploads/2013/01/13-January-15-NASADAD-Statement-on-MAT.pdf; https://www.cdc.gov/drugoverdose/prevention/treatment.html; and https://www.samhsa.gov/medication-assisted-treatment/treatment
[11] https://www.samhsa.gov/sites/default/files/mat-criminal-justice-panel-2011.pdf
[12] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf
[13]The report cites the following sources for each bullet, in order of the facts presented: Holder, HD. Costs Benefits of Substance Abuse Treatment: An Overview of Results from Alcohol and Drug Abuse. J. Mental Health Policy Econ, March, 1998.; Jones HE, Kaltenbach K, Heil SH, et al: Neonatal abstinence syndrome after methadone or buprenorphine exposure. New England Journal of Medicine 363:2320–2331, 2010; Baser, o., Chalk, M. Rawson, R. etal. (2001) Alcohol treatment dependence: comprehensive healthcare costs, utilization outcomes, and pharmacotherapy persistence. The American Journal of Managed Care, 178(8), S222- 234.; Walter, L. et al (2006). Medicaid Chemical Dependency Patients in a Commercial Health Plan, Robert Wood Johnson Foundation, Princeton, New Jersey.; and Holder, HD. Costs Benefits of Substance Abuse Treatment: An Overview of Results from Alcohol and Drug Abuse. J. Mental Health Policy Econ, March, 1998.

are less likely.[14] The National Institute of Drug Abuse echoes this sentiment, recommending MAT and noting that uninterrupted treatment can reduce drug use and criminal behavior.[15]

Box 1: Major Health Organizations Endorse MAT

In 2009, the **World Health Organization** recommended that countries make MAT available to patients who are addicted to opioids. "Recommendation (Minimum standard) Essential pharmacological treatment options should consist of opioid agonist maintenance treatment and services for the management of opioid withdrawal. At a minimum, this would include either methadone or buprenorphine for opioid agonist maintenance and outpatient withdrawal management. Recommendation (Best Practice) Pharmacological treatment options should consist of both methadone and buprenorphine for opioid agonist maintenance and opioid withdrawal, alpha-2 adrenergic agonists for opioid withdrawal, naltrexone for relapse prevention, and naloxone for the treatment of overdose."

In 2013, in response to public and private health insurance plans including MAT, the **National Association of State Alcohol and Drug Abuse Directors** issued a consensus statement affirming the "important role" that MAT can play in treating people with substance use disorders. "In all cases, the use of addiction medications should be considered and supported as a viable treatment strategy in conjunction with other evidenced based practices and as a path to recovery for individuals struggling with substance use disorders. In addition, NASADAD recommends that public and private health insurance plans cover medications for the treatment of opioid, alcohol, and nicotine dependence."

The **Center for Disease Control** (CDC)'s 2018 website acknowledges opioid substance-use disorders and names only one form of suggested treatment: MAT. The CDC emphasizes the importance of evidence-based treatment options.

The US Department of Health and Human Services' **Substance Abuse and Mental Health Services Administration** (SAMHSA) supports the use of MAT, writing that "MAT has proved to be clinically effective and to significantly reduce the need for inpatient detoxification services for these individuals [with opioid substance use disorders]." SAMHSA provides extensive information on MAT targeted towards different audiences, including researchers, medical providers, patients, and the public.

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2582162/ and https://www.ncbi.nlm.nih.gov/pubmed/18612373

[15] https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles and https://www.drugabuse.gov/publications/treating-opioid-addiction-in-criminal-justice-settings/treating-opioid-addiction-in-criminal-justice-settings

Box 2: MAT Cost Effectiveness

Report from Center for Medicaid and Medicare Services (CMA), Center for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and the National Institutes of Health.

- "Persons with untreated alcohol use disorders use twice as much health care and cost twice as much as those with treated alcohol use disorders, and medications treating SUDs in pregnant women resulted in significantly shorter hospital stays for SUD treatment than drug addicted pregnant women not receiving MAT (10.0 days vs. 17.5 days)."
- "For individuals with alcohol dependence, MAT was associated with fewer inpatient admissions. Total healthcare costs were 30 percent less for individuals receiving MAT than for individuals not receiving MAT."
- "Medical costs decreased by 33 percent for Medicaid patients over three years following their engagement in treatment. This included a decline in expenditures in all types of health care settings including hospitals, emergency departments, and outpatient centers."
- "Studies have shown that prior to alcoholism treatment initiation, total monthly health care costs increased and costs substantially increased during the 6–12 months prior to treatment. Following treatment initiation, monthly total medical care costs declined and the overall trend was downward. Early intervention in the cycle of addiction for younger individuals with SUDs can bring costs down as they have lower pre-treatment costs than older adults with SUDs."

How does MAT work?

MAT combines medication with behavioral interventions to treat opioid, alcohol, and tobacco substance use disorders. The types of medication differ depending upon the substance being used.

Medication for Opioids. MAT medications relieve opioid withdrawal symptoms and/or block the drugs' euphoric effects. The FDA has approved three types of medication to treat opioid addiction: methadone, buprenorphine, and naltrexone.

- Methadone, whose trade names include "Methadose" and "Dolophine"[16] is an oral tablet or liquid that "prevents opioid withdrawal symptoms and reduces craving by activating opioid receptors in the brain."[17] Methadone is administered to patients at federally designated methadone clinics, as a part of highly-regulated opioid treatment programs.
- Buprenorphine, whose trade names include Buprenex, Suboxone, Subutex, Zubsolv, Cizdol, Temgesic, and Sublocade[18] is administered under the tongue, as in injection, as a skin patch, or as an implant. It reduces or eliminates opioid withdrawal symptoms by both activating and

[16] https://www.deadiversion.usdoj.gov/drug_chem_info/methadone/methadone.pdf
[17] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf
[18] https://www.deadiversion.usdoj.gov/drug_chem_info/buprenorphine.pdf

blocking opioid receptors in the brain.[19] Buprenorphine can be prescribed so that is can be picked up at a pharmacy and taken at home. It is most commonly prescribed on a weekly basis by medical providers who have undergone a special certification course.

- Naltrexone, whose trade names include Vivitrol and Revia, may be injected or taken as a tablet, both of which block the effect of opioids.[20] Unlike buprenorphine and methadone, naltrexone is not an opioid. The injection form of naltrexone can be administered once per month. Naltrexone requires a detox period, which has made it more difficult for clients to begin naltrexone treatment.

MAT treatment of opioid addiction has yielded high success rates. A long-term NIH-funded study of patients treated with buprenorphine/naloxone, for example, found that three and a half years after the study, 61% of patients reported being abstinent across the past 30 days, and "fewer than 10 percent met diagnostic criteria for [drug] dependence."[21] (These patients were not specifically from the justice-involved population. They were volunteers for the Prescription Opioid Addiction Treatment Study.)

Medication for Alcohol. The FDA has approved three medications for treating alcohol use disorders: Acamprosate, Disulfiram, and Naltrexone. Disulfiram and Acamprosate are most effective for people who have already stopped drinking. Naltrexone blocks the euphoric effects of intoxication, allowing people who are struggling to abstain an option for treatment.[22]

Medication for Tobacco and Other Substances. For tobacco, the FDA recommends nicotine-replacement therapy or medicine that reduces the reward effects of nicotine. These include Varenicline tartrate (Chantix), Buproprion Hydrochloride (Zyban), and nicotine replacement therapies.[23] There is not yet a form of MAT to address methamphetamine use, however doctors indicate that such a drug may be on the horizon.[24]

Behavioral Health Treatment. In addition to medications, MAT involves behavioral health treatment. This treatment can come in different forms, including counseling, treatment of psychiatric disorders, behavioral modification, and referrals to community-based services.[25]

[19] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf
[20] https://www.mayoclinic.org/drugs-supplements/naltrexone-oral-route/description/drg-20068408
[21] https://www.drugabuse.gov/news-events/nida-notes/2015/11/long-term-follow-up-medication-assisted-treatment-addiction-to-pain-relievers-yields-cause-optimism
[22] https://www.samhsa.gov/medication-assisted-treatment/treatment
[23] https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm198176.htm
[24] https://www.drugabuse.gov/news-events/nida-notes/2018/05/narrative-discovery-quest-medication-to-treat-methamphetamine-addiction-part-3
[25] https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder

Box 3: MAT Medications			
Medication	*Trade Name*	*How Taken*	*Used for*
Methadone	Methadose, Dolophine	Pill, Liquid, or Oral Tablet	Opioids
Buprenorphine	Buprenex, Suboxone, Subtex, Zubsolv, Cizdol, Temgesic, Sublocade	Injection, Skin Patch, Implant, or Oral Tablet	Opioids
Naltrexone	Vivitrol, Revia	Injection, Oral Tablet	Opioids, Alcohol
Acamprosate	Campral	Oral Tablet	Alcohol
Disulfiram	Antabuse	Oral Tablet	Alcohol
Varenicline Tartrate	Chantix	Oral Tablet	Tobacco
Buproprion Hydrochloride	Wellbutrin, Zyban	Oral Tablet	Tobacco

Drug Courts Encourage Use of MAT

Since 1989, counties across the country have established drug courts to assess and supervise defendants with substance use disorders.[26] The courts channel defendants to treatment programs, monitor their progress, and—if defendants recover sufficiently—the courts dismiss defendants' cases.[27] California uses a system of collaborative courts, including drug courts, to "combine judicial supervision with rehabilitation services that are rigorously monitored and focused on recovery to reduce recidivism and improve offender outcomes."[28] These courts serving adults include the following types[29]:

- Adult Drug Courts,
- "DUI/DWI" (driving under the influence or driving while impaired) Courts,
- Family Dependency Drug Courts,
- Federal Reentry Courts,
- Homeless Courts,
- Mental Health Courts,
- Reentry Courts, and
- Veterans Treatment Courts.

National research over the past seven years indicates that the criminal justice system is a major source of referrals to substance addiction treatment programs, but most eligible clients are still not getting connected to MAT. A 2016 SAMSHA report using 2011 data found that the criminal justice system is the largest source of referral to substance addiction treatment programs.[30] A 2012 study from the Institute for Research, Education, and Training in Addictions, however found that only half of drug courts

[26] https://ireta.org/resources/3-barriers-to-medication-assisted-treatment-for-drug-court-participants-and-how-they-can-be-overcome/
[27] Ibid
[28] http://www.courts.ca.gov/programs-collabjustice.htm
[29] See Appendix F for descriptions
[30] https://www.samhsa.gov/data/sites/default/files/report_2321/ShortReport-2321.html

nationally refer clients to programs using MAT.[31] Most recently, a 2017 Health Affairs study using 2014 data reports that most justice-involved clients who are referred to opioid addiction treatment programs are not receiving MAT: "Only 4.6 percent of justice-referred clients received antagonist treatment [MAT medications], compared to 40.9 percent of those referred by other sources."[32]

Some states have made efforts to connect their justice-involved populations to MAT. In Rhode Island, for example, all inmates can receive MAT for opioid addiction while in jail; jails provide methadone, buprenorphine, and naltrexone to eligible clients.[33] Roughly 40 states, including California, have jails which will offer naltrexone to inmates as they near release.[34]

[31] https://ireta.org/resources/3-barriers-to-medication-assisted-treatment-for-drug-court-participants-and-how-they-can-be-overcome/ and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602216/
[32] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0890
[33] https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars
[34] https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars

MAT use in connection with California's collaborative courts

Research Methodology:

In August 2018, California Health Policy Strategies (CalHPS) conducted an online survey and telephone interviews to learn about how California's collaborative courts are—or are not—using MAT. The research team sought to identify the perceived need for MAT, barriers to implementing MAT, MAT success stories, and resource/information needs that could facilitate the use of MAT in the future.

The first stage of this research was an online survey, conducted in collaboration with Judicial Council. The 16-question, online survey aimed to secure a preliminary understanding of court professionals' knowledge, practices, and perceived resource needs. CalHPS and Judicial Council sent the survey to 290 collaborative court professionals. 44 people responded to the survey and 35 completed the survey, yielding a response rate of approximately 15%. 29 counties were represented in the sample. The survey cannot be considered a representative sample, but the results can offer a preliminary understanding of current practices and barriers. The online survey questions can be found in Appendix B.

The results of the online survey also informed subsequent, in-depth phone interviews with collaborative court professionals from nine counties. The phone interviewees were selected with the goal of having interviews with a cross-section of different counties and different professional affiliations. CalHPS sent interviewees questions in advance (see Appendix C). CalHPS asked interviewees to review their county's adoption of MAT, barriers and challenges to using MAT, efforts to overcome these barriers, and MAT-related plans for the future. The interviews were loosely structured according to these questions and ranged in time from a half hour to an hour long.

Take-Aways from Survey

- **Most collaborative courts use and understand MAT.** Most respondents reported that their courts used MAT and that they were at least "somewhat knowledgeable" about MAT.
- **There has been uneven uptake of MAT**. There is variation within and across counties, and across court types.
- **Few commonalities among non-MAT-using courts**. Courts that do not use MAT come from a range of counties (both urban and rural) and include many different types of courts.
- **Some courts lack information on MAT.** Several courts have not considered using MAT because they need more information about MAT or because they are unsure of MAT's efficacy.
- **The top reported reason for not using MAT was "lack of available MAT providers**."
- **Methamphetamine, not opioids, is the top drug of choice**. Methamphetamine was overwhelmingly the primary drug that justice-involved clients were using. Most courts reported that less than 25% of their population were using drugs that made them candidates for MAT.
- **Majority of respondents were affiliated with Adult drug courts.**

Courts that were not using MAT indicated the following reasons for not using MAT:

Respondent	Haven't heard about MAT before	Unsure of MAT's effectiveness	Unsure of how to implement MAT	Cost of implementing MAT	Lack of available MAT providers	Lack of support from team members
Veterans' treatment court					X	
Adult drug court			X			
Adult drug court	X					
Family dependency drug court	X	X	X		X	
Homeless court	X					
Mental health court					X	
Adult drug court		X		X	X	X
Mental health court						X
Adult drug court						X
Family dependency drug court		X	X	X	X	X

Courts that were using MAT indicated the following reasons for using MAT:

Answer Choices	Responses
Reduce drug use	22
Ensure adequate treatment	20
Reduce recidivism	15
Reduce crime	12
Increase public safety	11
Reunite families	11
Save money	3
Other: "fix the problem," "client already started before joining collaborative court," "better compliance with treatment"	3

It is interesting to note that "saving money" was not a key motivator for using MAT, although MAT has been shown to reduce overall health care costs, as well as costs to the justice system (e.g., due to lower re-arrest rates).

Take-Aways from Interviews

Barriers to Greater Use of MAT in Collaborative Courts

The most notable barriers to using MAT in collaborative courts were skepticism about MAT's efficacy, lack of available MAT resources, and the difficulty and expense of monitoring MAT compliance.

- **MAT skeptics.** Nearly every interviewee identified stigma against MAT and/or lack of knowledge about MAT as a key barrier. This bias exists at all levels: courts, judges, social workers, counselors, doctors and treatment providers, the community, and clients themselves were skeptical of MAT. This skepticism is reflected in the views of addiction treatment providers, law enforcement and public safety officials, and clients themselves:

    - **Addiction Treatment Skeptics.** Some treatment providers and councilors prefer an abstinence-based approach, which has been the cornerstone of substance use treatment for some time. Among these providers, some consider MAT to be "replacing one drug with another" and said that clients were not "clean" if they used MAT. Counselors, many of whom have recovered from addiction themselves, have seen the abstinence model work. Some treatment providers, however, have not yet seen MAT's success firsthand and others have seen MAT fail. In general, among treatment skeptics, there is a lack of knowledge about MAT and its efficacy. In some counties, MAT skepticism produced other barriers. Interviewees reported that in Placer county, a methadone treatment facility was unwilling to share information about its patients to other providers, because other providers "looked down upon" patients using MAT. In San Diego, some clients and treatment providers reportedly shamed MAT-using clients.

      In addition, multiple counties reported that in the past, MAT-using clients faced institutional barriers to treatment and re-entry; MAT-using clients were deemed ineligible for residential treatment because they "weren't clean" and social workers kept children from MAT-using parents because the parents "weren't clean." In San Francisco, a treatment program indicated that it did not partner with courts that had "different philosophies" regarding MAT—suggesting that some courts were skeptical of MAT.

    - **Public Safety Skeptics.** Similar to treatment provider skeptics, public safety skeptics' hesitations stem from greater familiarity with abstinence-based treatment models, lack of knowledge about MAT efficacy, and/or lack of firsthand experience with MAT success. One interviewee mentioned that their District Attorney was skeptical of MAT and considered it "another way to get high." Some public safety skeptics are also concerned that clients will sell their MAT drugs on the street—a valid and substantiated concern. In one county, for example, one treatment professional related an anecdote about how she convinced a judge to recommend MAT for a client, over the objections of the deputy district attorney. In an "I told you so" moment, the client was subsequently arrested for selling his MAT medication to purchase heroin. (In the aftermath of this incident, the district attorney's office continued to be generally supportive of MAT, a reflection of the strong underlying culture of support for the treatment option.)

- **Client Skeptics.** Like other populations, many clients are not familiar with MAT and/or have concerns about "replacing one drug with another." In addition, interviewees indicated that clients often distrust directives from authority figures such as court professionals or doctors. One interviewee reported that clients become skeptical when they receive conflicting information about how long someone needs to be on MAT. According to one treatment professional, for example, one client had heard that he would need to be on MAT for the rest of his life. Another client concern is whether the local jail offers MAT. This concern recognizes that a future incarceration while on MAT risks a harder detox experience in a jail that does not offer it.

- **Lack of available MAT resources.** Several respondents—especially from rural counties—cited lack of available MAT resources as a key obstacle to implementing MAT. In Fresno and El Dorado, for example, MAT treatment providers were often forty minutes to an hour drive away from clients. This made it difficult for clients to access MAT, especially when clients did not have a car and public transportation options were limited or unavailable.

  Interviewees from both rural and non-rural counties indicated that they needed more doctors who can provide prescriptions for MAT. Doctors are required to take a special 8-hour certification course to prescribe buprenorphine, and the number of patients that each approved physician can treat is limited to 100. These federal regulations limit the number of eligible buprenorphine-providers and patient access. Interviewees reported that some doctors are fearful of administering MAT, either because they are afraid of administering a drug incorrectly and "being shut down by the DEA" or because they are afraid that MAT drugs may negatively affect patients with other complicating health conditions.

- **Difficulty and expense of monitoring MAT compliance.** When a client's legal status is contingent upon treatment compliance, the court needs to know if the client is complying with treatment and abstaining from illegal drugs. Probation teams, for example, are interested in regular tests to indicate whether a client is using MAT correctly. However, one interviewee reported that MAT testing can be difficult and expensive. Standard drug tests in El Dorado county, for example, cannot differentiate between MAT and other drugs. From a legal and clinical perspective, it is important to know whether a client has MAT or another drug in his/her system. Additional tests can determine this, but in some counties these additional tests are difficult to obtain due to cost or laboratory capacity.

- **Other barriers.** Interviewees mentioned other key barriers, some of which were specific to their county's populations. Multiple counties mentioned that they were concerned about the street value of MAT drugs, noting that clients had sold MAT drugs in the past. In San Francisco, homelessness was a barrier: clients who stored their MAT drugs in backpacks, for example, had their backpacks stolen. San Francisco interviewees also mentioned that being close to other urban counties was a challenge, because clients often got arrested in neighboring counties which had different MAT policies.

How have counties, courts, and treatment providers overcome these barriers?

Despite these challenging barriers, many courts and counties have successfully implemented MAT. The following are proven, effective strategies for overcoming barriers to MAT for the criminal justice population.

- **Information campaigns.** Information campaigns were the most effective way to convert MAT skepticism into MAT support. Campaigns targeted treatment providers, courts, and the public.

  Interviewees from Placer county recounted a sustained, 5-year effort to bring about a cultural change that led to the integration of MAT in their collaborative court program. Senior staff in the Adult System of Care at Health and Human Services (HHS) were the first champions of MAT, and they worked hard to convince treatment providers and the courts to endorse this option. County Behavioral Health Department Adult System of Care leadership held educational meetings, trainings, and brown bags. They facilitated research-based presentations at leadership meetings and brought in expert speakers. Adult System of Care management encouraged their staff to attend educational meetings and brought providers to trainings. They worked with providers to minimize MAT stigma in client treatment groups. Throughout this process, Adult System of Care has worked to manage expectations, noting that they "can't guarantee outcomes."

  Similarly, in Butte county the public health department has conducted information campaigns directed at the public. These campaigns explain opiate addiction and how MAT works. An interviewee from Butte indicated that these campaigns have been effective in shifting public perception of addiction and MAT.

  An interviewee from Orange county also noted that trainings for attorneys in Orange County were effective in informing people about MAT and "winning them over."

- **Relationship-building between courts and treatment providers:** Relationship-building was important to promote MAT as a reliable treatment option and to facilitate the cooperation necessary to make MAT an effective treatment option. In Placer County, Adult System of Care organization with in the Health and Human Services Agency built ongoing relationships between the court and treatment staff. For a limited period of time, a Health and Human Services staff person was embedded within a court. This position was funded by a grant. While embedded in the court, the HHS staff person brought data and evidence of MAT efficacy to higher-level meetings. After the grant ended, the relationship between HHS and the courts continued. Today, case managers serve as liaisons between courts and treatment teams. They talk with the courts daily about their clients.

- **Consistent protocols and procedures.** Some counties established protocols and guides for use of MAT in the collaborative court context. This has helped systematize MAT implementation and cultivate buy-in. A public defender noted that Orange County protocols for MAT brought transparency and clarity. These protocols help courts determine when MAT might be appropriate and allow clients to make informed decisions. Similarly, Adult System of Care interviewees in Placer County developed a "suitability packet" containing a thorough set of recommendations based upon clinical judgement. This helped ensure uniform treatment recommendations and transparency,

which, in turn, cultivated buy-in and legitimacy. Moreover, Placer's switch to a hub-and-spoke model improved consistency of treatment.

- **Structural adjustments: hub-and-spoke model:** California is implementing a "hub and spoke" model for MAT treatment, with approximately 19 hubs and 119 spokes throughout the state.[35] "Hubs" are regional resources with a broad public health mission, including Narcotic Treatment Programs or Medication Units licensed by the Department of Health Care Services.[36] "Spokes" provide ongoing care for patients and have access to dedicated MAT teams.[37] Spokes can refer complex patients to the Hub in their region.[38]

  Interviewees reported that Placer county benefitted from a shift to a hub-and-spoke model of treatment, and Fresno county may benefit from this model in the future. In Placer, the hub-and-spoke model helped to get people in the same room to map out access points and to better train staff how to use the treatment system. The outcome has been improved consistency of treatment. A Fresno interviewee notes that the hub and spoke model—if it is successful—may be able to address the geographic access barriers that many clients are facing. At present, there is an effort in Fresno to connect emergency departments to the hub-and-spoke model.

- **Seeing MAT succeed.** Just as "seeing MAT fail" encouraged MAT skepticism, "seeing MAT succeed" restored optimism in MAT. One interviewee remarked that when people saw MAT working, it "open[ed] the door for others." It may be useful to provide information about success stories elsewhere when MAT skeptics have not seen success firsthand.

- **Leadership buy-in.** Virtually every county that was using MAT noted that leadership—judges, directors of treatment programs, high-ranking court personnel, and county officials—endorsed MAT. Counties identified at least one high-level champion of MAT who deserved credit for advancing MAT's use in collaborative courts. While some counties and courts' embrace of MAT began with a lower-level champion, counties and courts noted that a tipping point came when a judge became involved. While leadership buy-in is not enough to support MAT on its own, it may not be possible to integrate MAT in a systemic way without cultivating buy-in from judges, directors of treatment programs, high-ranking court personnel, and county officials such as county supervisors.

Other important take-aways from the research

Additional take-aways relevant to implementing MAT in partnership with collaborative courts include the following:

- **A small percentage of collaborative court clients are candidates for MAT**. When considering alcoholism as well, however, this number increases substantially in many counties. In most

[35] More information can be found at California Department of Health Care Services: https://www.dhcs.ca.gov/individuals/Pages/CA-Hub-and-Spoke-System.aspx and https://www.dhcs.ca.gov/individuals/Documents/CA_Hub_and_Spoke_FAQ.pdf
[36] Ibid
[37] Ibid
[38] Ibid

counties, the primary drug of choice is methamphetamines. Drug choice sometimes varies according to race and class. One interviewee noted that opiate users tend to be white, more financially stable, and less involved in the criminal justice system. Such observations have profound implications for health equity and suggest closer attention to the potential for drug treatment and programmatic restructuring to reduce stigma and improve racial disparities in health and criminal justice outcomes.

- **Many counties have multiple entry points to MAT**. As a best practice, anyone should be able to access MAT through their primary care providers. MAT is covered by Medi-Cal. For people who are involved with the justice system, access points to MAT vary by county. Some counties allow their clients to access MAT while in jail; some counties screen clients for MAT eligibility while in custody; and some counties mostly administer MAT when clients are out of jail.

- **For clients who are in jail but who are not using collaborative courts, access to MAT is usually limited**. Most jails do not currently administer MAT to clients were using MAT prior to incarceration. As a result, these clients "detox" in jail. The differences in the duration of action between opioids suggest that this "cold turkey" detox experience is even harder for clients using MAT than for those who are not using MAT. The effects of heroin, for example, last for a few hours, whereas the effects of methadone, a MAT medication, linger for days. Consequently, this painful detoxification process can dissuade clients from returning to MAT in the future. Moreover, clients whose detox involves benzodiazepines or alcohol can have even more severe detox syndromes, sometimes leading to death. Similarly, in many counties, clients who enter jail addicted to a drug (and not yet on MAT) are expected to "detox" while in jail. An interviewee from Santa Clara notes that jails are not seen as treatment facilities, and this is a barrier to administering MAT in jails.

- **Collaborative courts play different roles in different counties**. Sacramento interviewees described the county as "one big collaborative court" indicating that Sacramento courts give weight to treatment options in their decision-making processes. San Francisco interviewees emphasized their county's commitment to a "harm reduction model." In Butte, however, clients consider it "a privilege" to be in collaborative court because collaborative courts offer treatment in place of strong penalties. Butte clients are eager to comply because "they don't want to lose their spot" in a collaborative court, which would mean that they would have to return to an ordinary court.

Recommendations

There is strong evidence to support MAT for collaborative court clients. MAT is the leading treatment option due to its medical success, its proven cost-saving capacity, and its potential to reduce recidivism and save lives. Nonetheless, cultural, access, and resource barriers limit California courts' capacity to recommend MAT to their clients. To address these barriers and foster MAT-supportive collaborative court environments, CalHPS recommends that courts, counties, and treatment providers do the following:

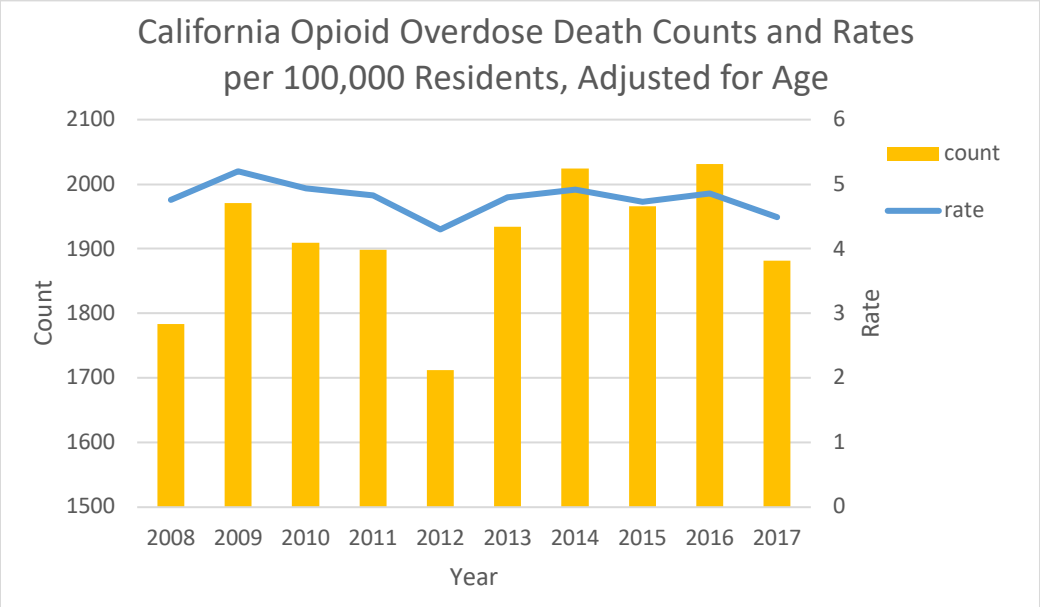
- **Circulate information on MAT tailored to different audiences.** There are ample research findings and communications materials about MAT in general and MAT in the criminal justice context. Given that information was a key barrier to adopting MAT, this report recommends that MAT information be disseminated to courts, doctors, potential clients, and other treatment providers. It will be important to tailor this information to each audience to address their concerns. (Doctors, for example, might benefit from information which discusses different MAT medications and ways to avoid interactions with other medications. Courts and treatment providers, moreover, may benefit from information detailing the different modes of MAT treatment. Information campaigns can be a crucial step in achieving cultural change around MAT.

- **Coordinate justice system and community treatment services.** Treatment providers and courts discussed the difficulties that arise when jails do not have the same approach to MAT as community treatment providers. Throughout California, clients who enter jail while on MAT will not receive MAT medication. This is harmful to the client's recovery process. If jails and community services share information and procedures pertaining to MAT treatment, clients may be able to undergo treatment with fewer interruptions and delays.

- **Ensure that MAT services are available throughout the correctional justice system, including jails and prisons.** As noted above, interruptions in a client's MAT treatment can have severe negative effects on the client's recovery process. For this reason, it is important for clients to have continued access to treatment at each point of involvement with the correctional justice system.

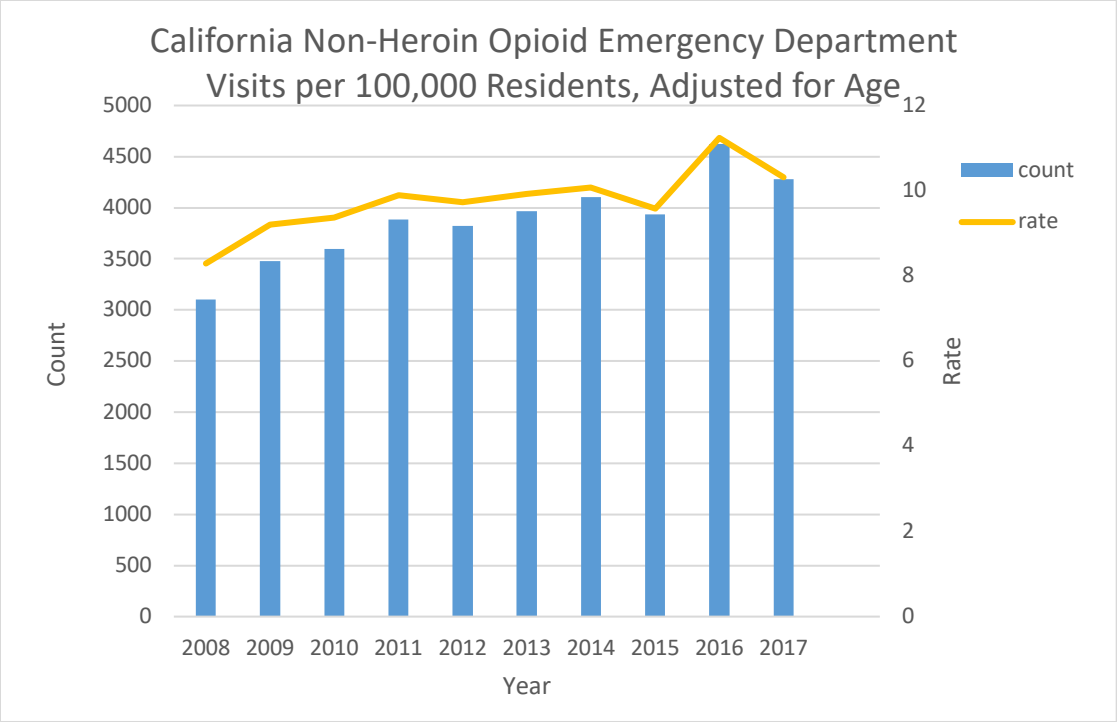
- **Document MAT policies, roles, and responsibilities.** Courts and treatment professionals have reported that it was helpful to have a written document describing how to connect collaborative court clients with MAT. Different stakeholders referred to this document when determining MAT eligibility and referring clients to MAT. MAT manuals and guides helped to ensure consistency of treatment. They also clarified roles and procedures, further cultivating buy-in. Courts and counties looking to adopt MAT would likely benefit from developing MAT guidelines to share with courts, treatment providers, and any other interested stakeholders.

Appendix A: 2017 Estimates of Opioid Deaths and Emergency Department Visits in California[39]



Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by CalHPS

[39] Data from CDPH Vital Statistics Multiple Cause of Death Files https://discovery.cdph.ca.gov/CDIC/ODdash/
Prepared by: CalHPS



Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by CalHPS.

Appendix B: Opioid Overdose Deaths by California County[40]

Table 1: Opioid Death Rates in Counties with Highest Opioid Overdose Death Rates in 2017 (Age-Adjusted Rates per 100,000 Residents)

County	2013	2014	2015	2016	2017
Modoc	12.84	14.2	7.16	0	23.78
Humboldt	13.42	18.81	18.05	22.35	20.99
Lake	29.81	22.86	26.92	11.52	15.19
Mendocino	10.61	16.96	15.05	17.34	13.47
Yuba	0	4.46	6.14	8.08	13.37
Del Norte	21.4	7.25	10.21	11.01	12.68
Shasta	11.85	10.47	8.97	8.64	12.13
Lassen	14.67	13.34	10.51	19.86	11.9
Siskiyou	0	6.63	17.31	21.98	10.16
San Benito	8.54	4.6	5.23	3.85	9.53

Table 2: Deaths in Counties with Highest Opioid Overdose Death Counts in 2017 (Age-Adjusted)

County	2013	2014	2015	2016	2017
Los Angeles	292	284	276	353	354
San Diego	260	239	247	251	272
Orange	245	249	251	287	207
Riverside	129	142	134	112	125
Ventura	65	62	52	44	79
San Francisco	75	70	95	94	74
Kern	45	71	75	54	71
Santa Clara	53	55	66	68	59
San Joaquin	64	69	46	53	57
Contra Costa	42	50	49	53	45

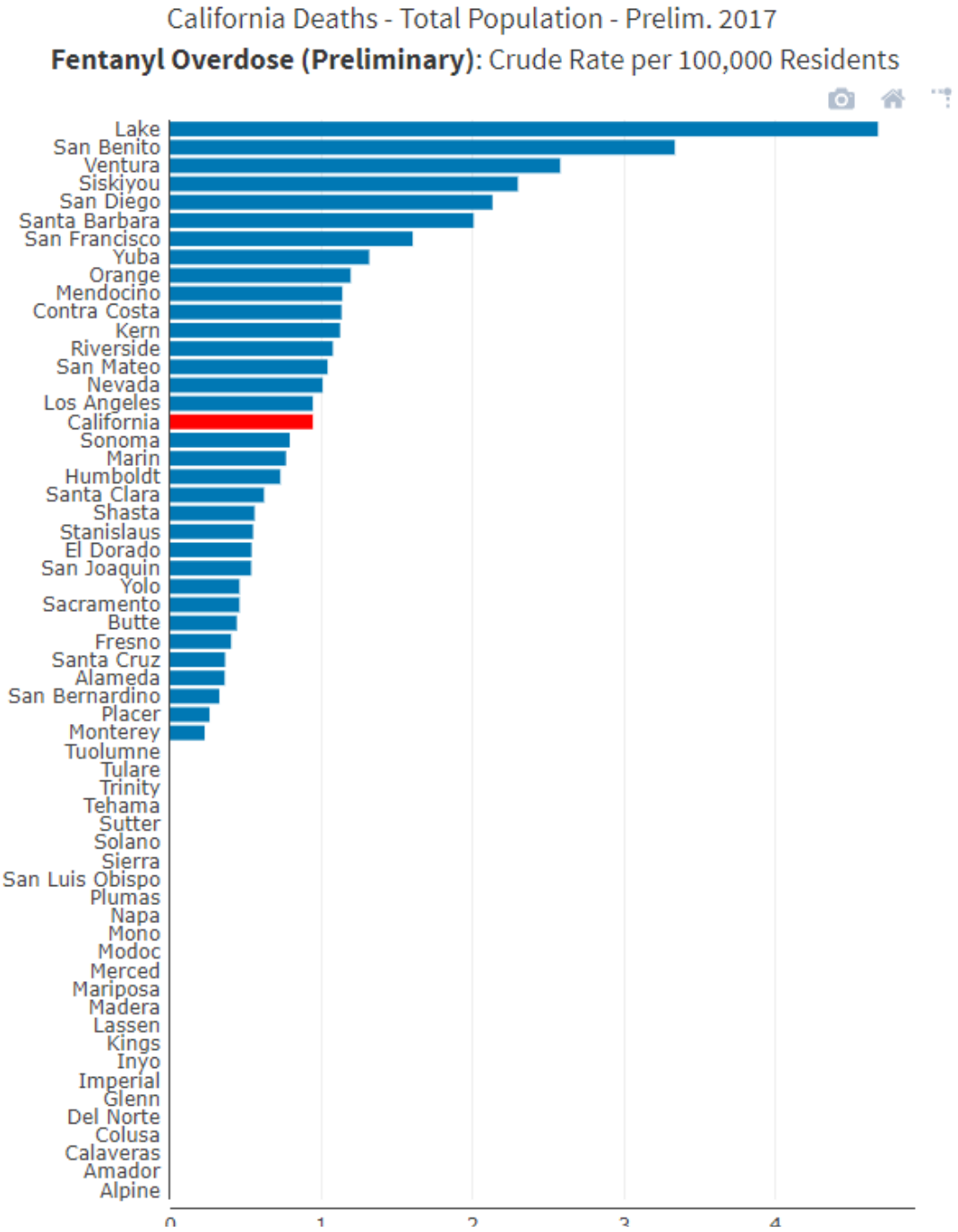
[40] Data from CDPH Vital Statistics Multiple Cause of Death Files https://discovery.cdph.ca.gov/CDIC/ODdash/
Prepared by: CalHPS

Table 3: Death Rates in Counties with Largest Increases and Decreases in Opioid Overdose Death Rates Between 2013 and 2017 (Age-Adjusted Rates per 100,000 Residents)

County	**2013**	**2014**	**2015**	**2016**	**2017**	**% Change from 2013 to 2017**
			Counties with increased Rates			
Yuba	0	4.46	6.14	8.08	13.37	+13.37
Modoc	12.84	14.2	7.16	0	23.78	+10.94
Siskiyou	0	6.63	17.31	21.98	10.16	+10.16
Humboldt	13.42	18.81	18.05	22.35	20.99	+7.57
			Counties with Decreased Rates			
Plumas	31.18	20.52	31.3	0	2.02	-29.16
Trinity	23.68	3.89	6.95	13.4	4.41	-19.27
Lake	29.81	22.86	26.92	11.52	15.19	-14.62
Inyo	15.52	0	0	22.91	3.19	-12.33

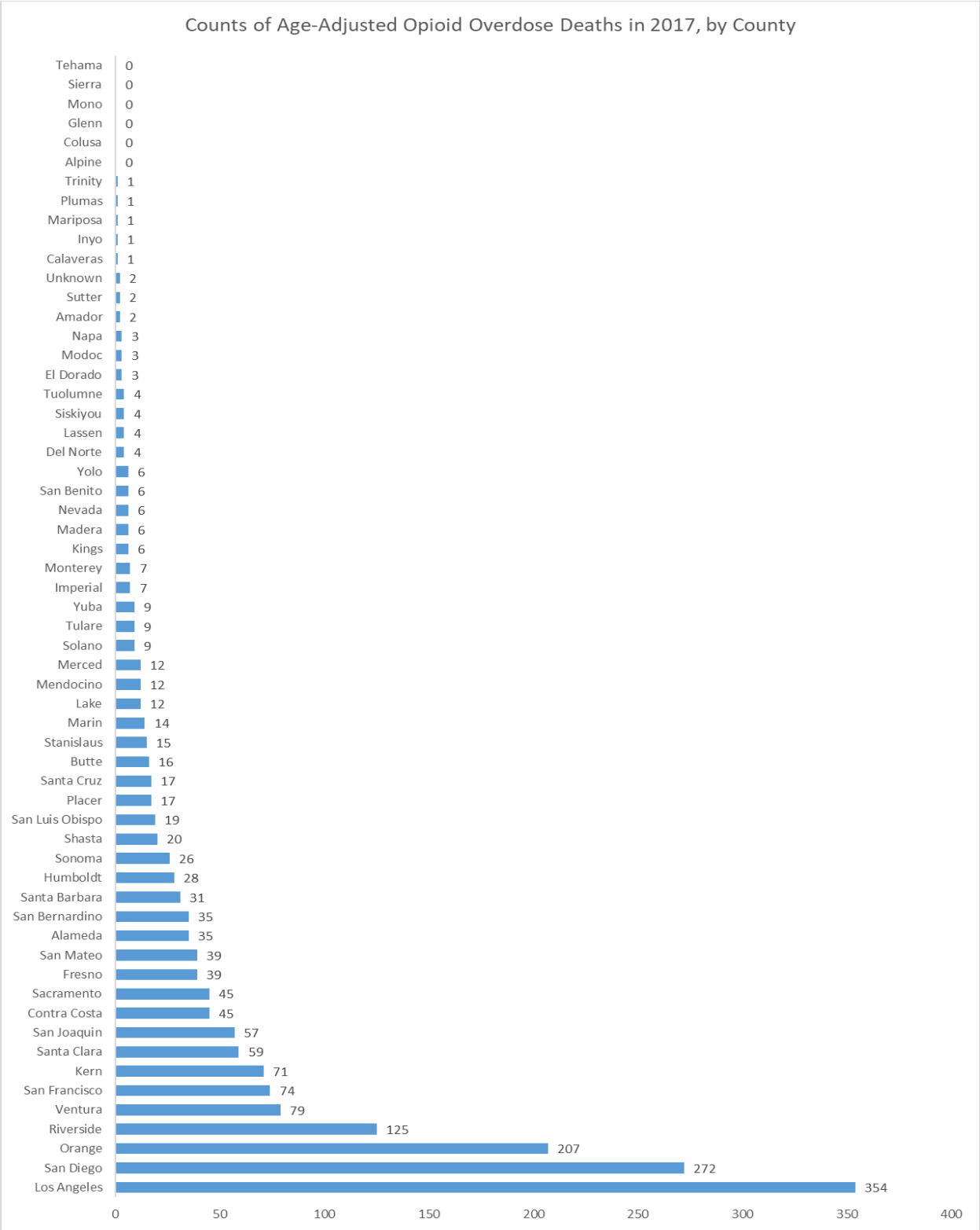
Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by CalHPS

Appendix C: Additional Opioid Graphs and Charts for California[41]

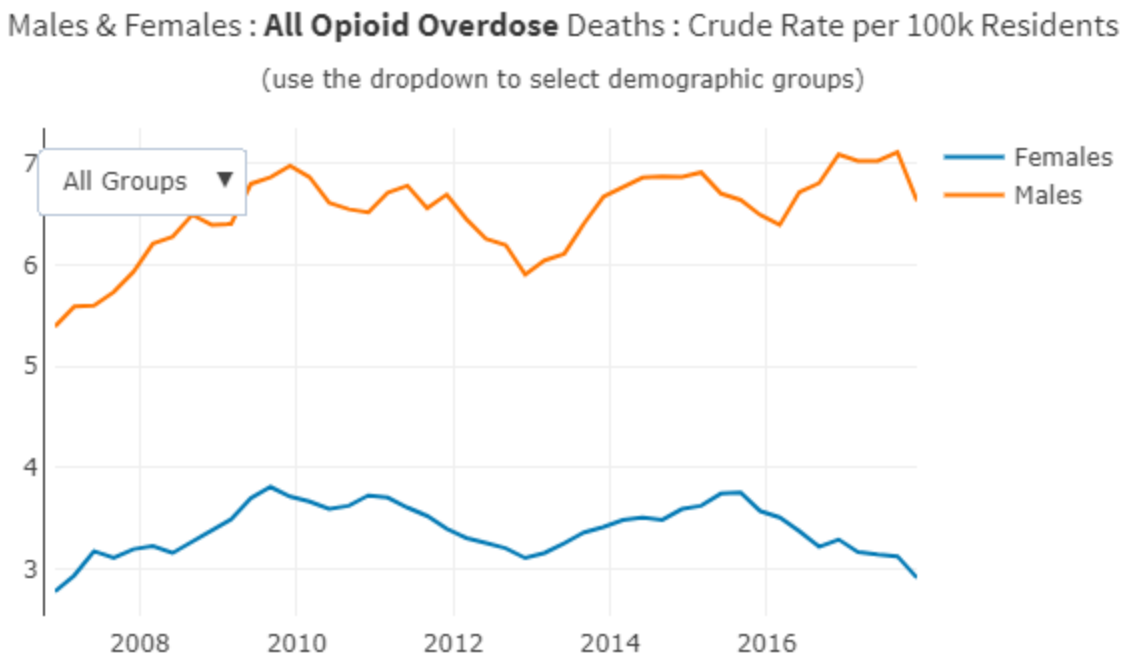


Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by California Department of Public Health, Safe and Active Communities Branch.

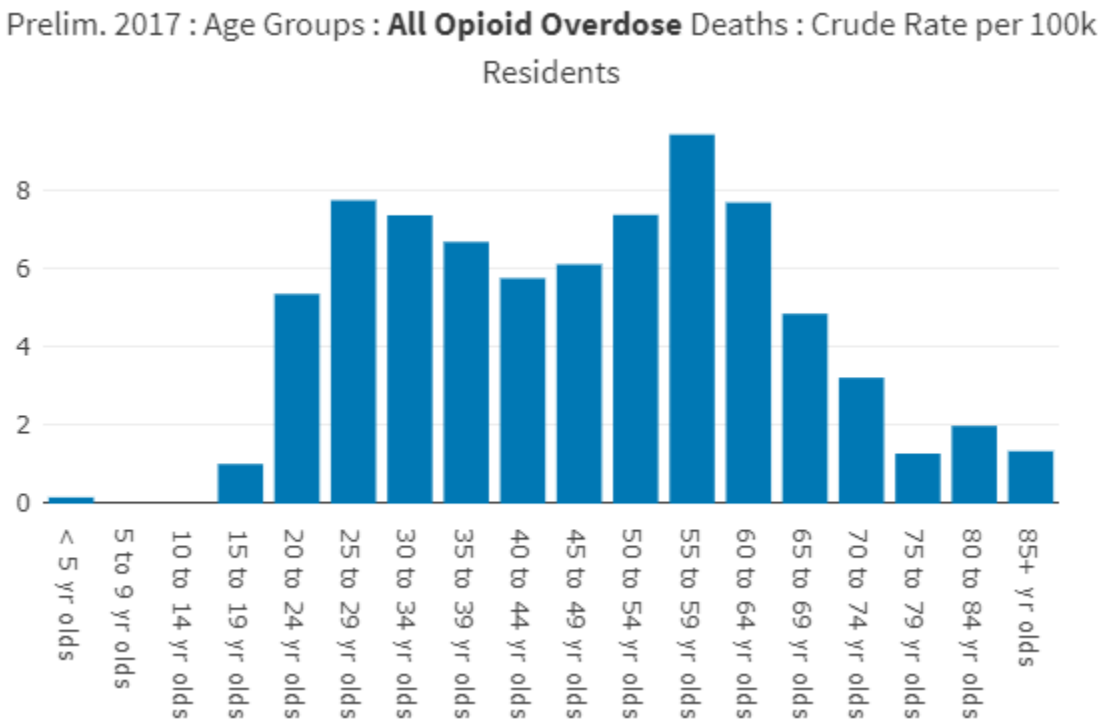
[41] CDPH Vital Statistics Multiple Cause of Death Files https://discovery.cdph.ca.gov/CDIC/ODdash/
Prepared by: California Department of Public Health, Safe and Active Communities Branch.



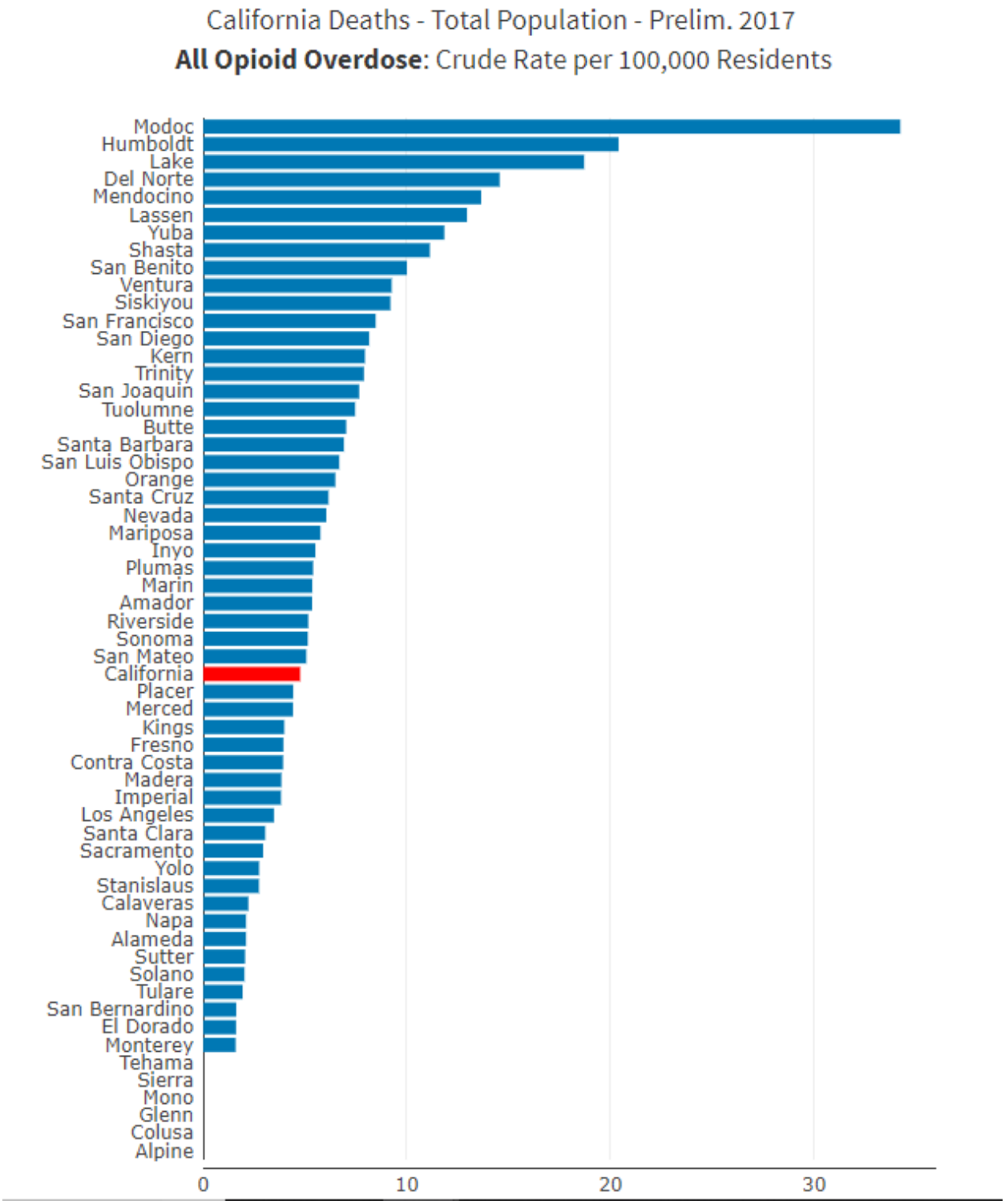
Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by California Department of Public Health, Safe and Active Communities Branch.



Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by California Department of Public Health, Safe and Active Communities Branch.



Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by California Department of Public Health, Safe and Active Communities Branch.



Source: CDPH Vital Statistics Multiple Cause of Death Files, prepared by California Department of Public Health, Safe and Active Communities Branch.

Appendix D: Online Survey Questions

Collaborative Court MAT Survey

Page 1

1. Basic info: what kind of court are you? Please check all that apply.
    a. Adult Drug court
    b. Back on TRAC (treatment responsibility accountability on campus)
    c. DUI/DWI court
    d. Family dependency drug court
    e. Federal district drug court (federal re-entry court)
    f. Homeless court
    g. Mental health court
    h. Re-entry court
    i. Tribal healing to wellness court
    j. Veterans' treatment court
    k. Co-occurring court
2. Are you and others at the court familiar with MAT (Medication-Assisted Treatment)?
    a. Yes
    b. No
3. Of the people coming through your court who are experiencing addiction, which substances are they addicted to, specifically? Check all that apply.
    a. Methamphetamine
    b. Alcohol
    c. Opioids
    d. Heroin
    e. Marijuana
    f. Other _____

Page 2

MAT is a well-established technique to treat substance use disorders. MAT integrates behavioral and physical health, combining behavioral therapy with administration of three medications: methadone, buprenorphine, and/or naltrexone.

4. Does this court currently use MAT?
    a. Yes
    b. No

If NO, go to page 3. If YES, go to page 4.

Page 3

If NO on #3 (this court is not using MAT), please answer the following questions:

5. Has this court considered using MAT at any time?

a. Yes
b. No

6. What are the court's reasons for not using MAT? Check all that apply and add any that are missing.
    a. Haven't heard about MAT before
    b. Unsure of MAT's effectiveness
    c. Unsure of how to implement MAT
    d. Cost of implementing MAT
    e. Other (please write in) _____
7. Does the court actively prohibit use of MAT?
    a. Yes
    b. No
8. Are there any other details or question that you would like to share at this time?
    a. Open box for comments

Page 4

If YES on #3 (this court is currently using MAT), please answer the following questions:

4. How many of this court's clients use MAT?
    a. 0-25%
    b. 25%-50%
    c. 50%-75%
    d. 75%-100%
    e. Other number or percentage _____
2. What types of addiction are being treated with Mat? Check all that apply
    a. Methamphetamine
    b. Alcohol
    c. Opioids
    d. Heroin
    e. Marijuana
    f. Other _____
5. What is this court's top reasons for using MAT? Check all that apply and add any that are missing.
    a. Save money
    b. Reduce recidivism
    c. Ensure adequate treatment
    d. Increase public safety
    e. Reduce crime
    f. Reduce drug use
    g. Restore lives
    h. Reunite families and save children
    i. Other (please write in) _____
6. What elements does this court's MAT program include? Check all that apply and add any that are missing.
    a. Counseling
    b. Individualized selection of treatment programs
    c. Required regular communication with treatment programs regarding participant progress

d. Screening and assessments that consider all clinically appropriate forms of treatment
e. Judges who rely upon the clinical judgement of treatment providers/clinical staff,
f. Monitoring for illicit use of MAT medication,
g. Medications covered trough government and/or private insurance programs
h. Other (please write in) _____

7. Are there any other details or question that you would like to share at this time?
    a. Open box for comments

Appendix E: Interview Questions

Collaborative Court and MAT long-form questions

California Health Policy Strategies is working with Judicial Council to better understand how collaborative courts and the justice system more broadly uses MAT (Medication-Assisted Treatment). Our findings will be shared at the collaborative court conference in September.

Background

- Does your court use MAT?
- If yes…
    - When did your court start using MAT? How did this start? What was the process like?
    - Before starting MAT, what were the pros/cons that people identified to using MAT? Have these matched up to the reality now that your court is implementing MAT?
- If no…
    - Has your court ever considered using MAT? If so, what did those discussions look like? What were the pros/cons that your court considered?
    - If you have not considered using MAT, any sense as to why not?

Status today

- If using MAT…
    - What is working and what isn't working?
    - What are the elements of your MAT program?
    - How is your MAT program implemented? What are the steps? (For example, who decides that a patient will begin MAT? How does the process begin? Is it a condition of probation?)
    - Any metrics on MAT outcomes?
- If not using MAT…
    - Are there any discussions about the possibility of implementing MAT? Why/why not?

Future

- If using MAT…
    - What do you plan to do in the future?
    - Are there any plans to expand MAT?
- If not using MAT…
    - Do you think there is a possibility of your court implementing MAT in the future?

Appendix F: Types of Collaborative Justice Courts[42]

Adult Drug Court. A specially designed court calendar or docket, the purposes of which are to achieve a reduction in recidivism and substance overuse among nonviolent substance abusing offenders and to increase the offender's likelihood of successful habilitation through early, continuous, and intense judicially supervised treatment, mandatory periodic drug testing, community supervision, and use of appropriate sanctions and other rehabilitation services.

DUI/DWI Courts. A DWI court is a distinct post-conviction court system dedicated to changing the behavior of the alcohol-dependent repeat offender arrested for driving while impaired (DWI). The goal of the DWI court is to protect public safety by using the drug court model to address the root cause of impaired driving: alcohol and other drugs of overuse. Variants of DWI courts include drug courts that also take DWI offenders, which are commonly referred to as "hybrid" DWI courts or DWI/drug courts. DWI courts often enhance their close monitoring of offenders using home and field visits, as well as technological innovations such as Ignition Interlock devices and the SCRAM transdermal alcohol detection device.

Family Dependency Drug Court. Family dependency treatment court is a juvenile or family court docket of which selected abuse, neglect, and dependency cases are identified where parental substance use disorder is a primary factor. Judges, attorneys, child protection services, and treatment personnel unite with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents the necessary support and services to become drug and alcohol abstinent. Family dependency treatment courts aid parents in regaining control of their lives and promote long-term stabilized recovery to enhance the possibility of family reunification within mandatory legal timeframes.

Federal District Drug Court (Federal Re-Entry Court). Federal district drug court is a post-adjudication, cooperative effort of the Court, Probation, Federal Public Defenders, and U.S. Attorneys' Offices to provide a blend of treatment and sanction alternatives to address behavior, rehabilitation and community re-integration for non-violent, substance-abusing offenders. These courts typically incorporate an early-discharge program designed to replace the final year of incarceration with strictly-supervised release into the drug court regimen. The Federal programs incorporate the Ten Key Components in a voluntary but contractual program of intense supervision and drug testing lasting a minimum of 12–18 months.

Homeless Courts. Homeless Courts are special court sessions held in a local shelter or other community site designed for homeless citizens to resolve outstanding misdemeanor criminal warrants (principally "quality-of-life" infractions such as unauthorized removal of a shopping cart, disorderly conduct, public drunkenness, and sleeping on a sidewalk or on the beach). Resolution of outstanding warrants not only meets a fundamental need of homeless people but also eases court case-processing

[42] https://www.ca2c.org/types-of-collaborative-justice-courts/

backlogs and reduces vagrancy. Homeless people tend to be fearful of attending court, yet their outstanding warrants limit their reintegration into society, deterring them from using social services and impeding their access to employment. They are effectively blocked from obtaining driver's licenses, job applications, and rental agreements.

Mental Health Courts. Mental Health Courts connect offenders who would ordinarily be prison-bound to long-term community-based treatment. They rely on mental health assessments, individualized treatment plans, and ongoing judicial monitoring to address both the mental health needs of offenders and public safety concerns of communities. Like other collaborative justice courts, mental health courts seek to address underlying problems that contribute to criminal behavior. Mental Health Courts utilize mental health professionals, on-going counseling and substance use disorder treatment, Crisis Intervention Teams, jail diversion, and specialized probation and parole caseloads to address the disproportionate number of people with mental illness in the criminal justice system.

Re-Entry Courts. Reentry drug courts utilize the drug court model, as defined in The Key Components, to facilitate the reintegration of drug-involved offenders into communities upon their release from local or state correctional facilities. Reentry drug court participants are provided with specialized ancillary services needed for successful reentry into the community. These are distinct from reentry courts, which do not utilize the drug court model, but work with a similar population.

Veterans' Treatment Courts. Drug Courts around the country have seen rising numbers of veterans in their programs and sought to offer specialized services to address their unique needs. The Veterans Treatment Court model use veterans as mentors to help defendants engage in treatment and counseling as well as partner with local Veterans Affairs offices to ensure that participants receive proper benefits. Veterans' Treatment Courts have garnered national media attention and widespread interest in the Drug Court field.

Appendix G: Additional Resources on the Opioid Crisis and MAT

Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts, National Drug Court Institute, August 2016: https://www.ndci.org/wp-content/uploads/2009/04/mat_fact_sheet-1.pdf

Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence, Substance Abuse and Mental Health Services Administration (SAMHSA), Summer 2014: https://store.samhsa.gov/shin/content/SMA14-4852/SMA14-4852.pdf

Only One in Twenty Justice- Referred Adults in Specialty Treatment for Opioid Use Receive Methadone Or Buprenorphine, Health Affairs, 2017: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0890

A Technical Guide for Drug Court Judges on Drug Treatment Services, Bureau of Justice Assistance Drug Court Technical Assistance Project, American University, 2014. https://www.american.edu/spa/jpo/initiatives/drug-court/upload/A-Technical-Assistance-Guide-for-Drug-Court-Judges-on-Drug-Court-Treatment-Services.pdf

3 Barriers to Medication-Assisted Treatment for Drug Court Participants and How They Can Be Overcome, Institute for Research, Education and Training in Addictions: https://ireta.org/resources/3-barriers-to-medication-assisted-treatment-for-drug-court-participants-and-how-they-can-be-overcome/

Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes, Journal of Substance Abuse Treatment, May 2013: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602216/

Joint Public Correctional Policy on the Treatment of Opioid Use Disorders for Justice Involved Individuals, American Correctional Association, 2018: https://www.asam.org/docs/default-source/public-policy-statements/2018-joint-public-correctional-policy-on-the-treatment-of-opioid-use-disorders-for-justice-involved-individuals.pdf?sfvrsn=26de41c2_2

Medication Assisted Treatment in Drug Courts: Recommended Strategies, Center for Court Innovation, State of New York, Unified Court System, 2016: https://lac.org/wp-content/uploads/2016/04/MATinDrugCourts.pdf

Strategies to Increase MAT Prescribing, Association for Community Affiliated Plan, Prepared by Health Management Associates, 2018: http://www.communityplans.net/wp-content/uploads/2018/06/ACAP-Strategies-to-Increase-MAT-Prescribing.pdf

Stem the Tide: Addressing the Opioid Epidemic, American Hospital Association, 2017: https://www.aha.org/system/files/2018-06/stem-the-tide-addressing-opioid-epidemic.pdf

Why Health Plans Should to go the "MAT" in the Fight Against Opioid Addiction, California Health Care Foundation, 2017: https://www.dropbox.com/home/consulting/Projects/Drug%20treatment%20-%20Opiod?preview=PDF+Why+Health+Plans+Should+Go+to+the+MAT.pdf

Medication Assistance in Treatment Courts, Video with Terrance Walton, National Drug Court Institute: https://www.ndci.org/resources/training/medication-assisted-treatment/

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About California Health Policy Strategies (CalHPS), LLC.

- CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com