

# Position Statement on Treatment of Substance Use Disorders in the Criminal Justice System

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### Issue:

In 2004, 53% of state prison inmates and 45% of federal prison inmates met APA criteria for substance abuse or dependence, according to a 2007 report from the Bureau of Justice Statistics <sup>(2)</sup>. About half had a history of treatment for their disorder before arrest. Rates were even higher for jail inmates, with females, for whom the incarceration rate is growing faster than males, demonstrating higher rates of substance dependence than males <sup>(3)</sup>. In a 2013 SAMHSA survey, it was found that 35% of adults on probation and 34.3% of adults on parole had a substance use disorder compared to 8% among adults who were not on probation or parole <sup>(4)</sup>. Similarly, about two-thirds of inmates detained when they were 18 years old or younger had a substance use disorder <sup>(5)</sup>. A significant body of public health research has shown that treating criminal offenders' substance use disorders diminishes the likelihood of relapses and other adverse health outcomes while also reducing the overall financial burden on society of lost productivity, crime, and additional incarcerations <sup>(6)</sup>. Although many offenders enter the criminal justice system with significant resistance to engaging in treatment for their substance use disorders, those offenders who are mandated into substance use treatment can achieve similar treatment outcomes to those seeking voluntary treatment <sup>(6)</sup>. It is of vital importance given that the 30 days after release from incarceration are a time of heightened overdose and mortality risk.

### POSITION:

Evidence-based treatment for substance-related disorders is too often lacking for those individuals in the criminal justice system with substance use disorders. It is the position of the American Psychiatric Association that:

1. Whenever appropriate, drug courts and driving-while-intoxicated courts should be given serious consideration as viable options for eligible adults and juveniles whose cases are being heard in adult courts. These alternative courts should assure high-quality, culturally- and gender-relevant evaluation, treatment, and monitoring are provided.
2. All arrestees and sentenced inmates should be screened and pertinent history taken for the presence of substance use disorders, withdrawal syndromes and comorbid illnesses such as mood and anxiety disorders, PTSD, hepatitis C, tuberculosis and HIV by the receiving jail or prison and offered appropriate laboratory testing if clinically indicated. The screening assessments should be documented in the detainee's health care records. Correctional facilities should be prepared either to provide quality treatment for alcohol or drug withdrawal and associated comorbidities, or to arrange timely transfer to an appropriate medical facility if medically supervised withdrawal services are not available onsite.
3. Health professionals who provide care in jails and prisons should be educated in screening for withdrawal syndromes and for substance use disorders, and in the treatment of these disorders. Other staff that has contact with inmates or responsibility for their care should also be educated about substance-related disorders and identification of emergent problems.

4. Jails and prisons should make available quality treatment for substance use disorders to all inmates who qualify for such treatment. This should include medically-supervised withdrawal, treatment for short-term pretrial detainees, a comprehensive psychiatric evaluation, and treatment with appropriate medication for offenders sentenced to prison terms. In addition, non-pharmacologic interventions such as individual counseling, group psychotherapy, mutual-help support groups (e.g. Alcoholics Anonymous, Narcotics Anonymous), relapse prevention strategies, and pre-release planning (including referrals to vocational training resources, housing assistance, and psychological/medical support) should be provided to ensure adequate follow-up treatment on a residential or outpatient basis after release. Detainees should be encouraged to make use of these resources.
5. Medications constitute an essential part of treatment for many offenders with substance use disorders, particularly opioid use disorders. Methadone and buprenorphine save lives by preventing relapse and reducing the risk of opioid overdose. Arrestees who are being treated with methadone or buprenorphine for their opioid use disorder in the community should be maintained on the appropriate dosage of their medication while in jail and prison in coordination with their treatment providers in the community, whenever possible. If continued treatment with this medication is not possible or not indicated, medically-supervised withdrawal should be provided. At a minimum, naloxone rescue kits should be readily available in prisons, and staff trained in using them. All incarcerated persons in jail or prison with opioid use disorders should receive overdose education. To prevent opioid overdose deaths, naloxone rescue kits should be provided upon release from incarceration. .
6. Substance use programs in jails and prisons should monitor participants with scientifically-valid toxicology tests for current alcohol/drug use if the law within their jurisdiction allows it.
7. For any offender with a substance use disorder, probation or parole should be conditional on receiving treatment of the substance use disorder whenever appropriate and clinically recommended. For any parolee who has received pre-release substance use disorders treatment, continued cooperation in follow-up treatment should be a condition for continuation of parole.
8. It is essential for continuity of care that offenders who received some form of substance use treatment while incarcerated have community treatment resources available after release. Aftercare planning should include attention to the medical, mental health and substance use disorder needs of inmates and detainees as well as regular, random testing for substance use, coupled with low-level sanctions for relapses. When indicated, inmates and detainees should be referred to programs specializing in the treatment of individuals with co-occurring psychiatric and addictive disorders. The menu of options for aftercare should include the entire spectrum of addiction programs, including treatment with medications for alcohol and opioid use disorders (e.g. methadone, buprenorphine, extended-release injectable naltrexone), outpatient psychosocial interventions, and residential rehabilitation facilities.
9. Psychiatrists, especially addiction psychiatrists and others with a strong background in treating substance use disorders, should lend their expertise to courts, correctional facilities, and community providers who receive individuals upon re-entry.

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