Addiction Treatment: Cures for Recidivism

ASAM American Society of Addiction Medicine

JUSTICE PROGRAMS OFFICE
SCHOOL of PUBLIC AFFAIRS

ISSUE BRIEF: BUREAU OF JUSTICE ASSISTANCE TRAINING & TECHNICAL ASSISTANCE PROGRAM FOR STATE ADMINISTERING AGENCIES

Individuals with a substance use disorder (SUD) represent a significant proportion of those behind bars. Half of federal prisoners are incarcerated on drug-related offenses.[1] In addition, 85% of prisoners are there for substance-related reasons, meaning they either have an active or prior SUD or committed their crime while intoxicated or to obtain money for drugs.[2] SUD is also highly prevalent among probationers and two-thirds are alcohol or drug involved.[3] In many cases, these offenses are a manifestation of the disease of addiction rather than a criminal proclivity, and providing addiction treatment is effective in preventing recidivism.

Addiction:

A primary, chronic, progressive, and potentially fatal brain disease, which affects individuals' motivation, memory, and emotions and results in an inability to consistently abstain from substances.

[www.asam.org/research-treatment/definition-of-addiction]

Research has shown that treatment improves clinical outcomes and reduces crime, recidivism, and societal costs; however, care within correctional facilities varies widely and often does not meet community standards of care. Lack of adequate healthcare for prisoners has been ruled by the Supreme Court to be cruel and unusual punishment, and jails and prisons are required to provide the community standard of care.[4]

That most prisoners do not receive treatment from a trained clinician is particularly troubling because addiction is a treatable disease.[5] The vast majority of prisoners will eventually be released, and the burden of their untreated SUD will only worsen the massive societal costs of addiction, including through repeat criminal actions. The most striking example is the lack of access to *pharmacotherapy*, which is legally prescribed and dispensed FDA approved addiction treatment medications to manage withdrawal, stabilization and, as necessary, ongoing maintenance of recovery. *Medically Assisted Treatment (MAT)* combines behavioral therapy and medications to treat substance use disorders. There is strong evidence for the efficacy of these treatments.[6]

The World Health Organization recommends that all individuals with opioid use disorder be offered treatment with opioid agonists, yet less than 0.3% of prisoners are treated with pharmacotherapy.[7,8] Although opioid agonist medications have been recommended for inclusion in drug courts by the National Drug Court Institute, a minority of drug courts offer buprenorphine or methadone maintenance treatment.[9,10] A 2013 study found only 34% of drug courts permit agonist therapy for untreated participants and only 40% allow continued treatment for participants already on agonist therapy.[11] Promisingly, a 2015 report suggests improvement in acceptance of agonist therapy among drug courts, with more courts reporting allowance of medication treatments with fewer restrictions on duration of treatment; though research suggests a large portion of courts still do not utilize MAT.[12]

Lack of treatment will also contribute to the staggering death toll following release, especially recognizing that former prisoners have a 129 times higher risk of death from overdose.[13] Like all individuals, prisoners deserve access to evidence-based care for SUD. Criminal justice settings offer an important opportunity to initiate treatment in vulnerable populations and to provide linkage to community-based care that will ultimately save lives and resources.

WHAT IS AN AGONIST? WHAT IS AN ANTAGONIST?

agonist medications pharmacologically occupy opioid receptors in the body. They thereby relieve withdrawal symptoms and reduce or extinguish cravings for opioids.[15]

Opioid antagonist medication: Opioid antagonist medications pharmacologically occupy opioid receptors in the body, but do not activate the receptors. This effectively blocks the receptor, preventing the brain from responding to opioids. The result is that further use of opioids does not produce euphoria or intoxication.[16]

Practice Pointers

Drug-related offenses that result from a person suffering from the disease of addiction require treatment, not incarceration, to most effectively achieve increased public safety and decreased legal recidivism and crime. In treating addiction as a primary chronic disease, *The ASAM Criteria* are the most widely used and researched comprehensive set of guidelines for assessment, service planning, placement, continued stay and discharge of people with addiction. The current edition, *The ASAM Criteria - Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (2013) includes a chapter specifically designed to assist in the application of the ASAM Criteria to people in criminal justice settings.[14]

With the large proportion of individuals incarcerated for drug-related offenses, and a large proportion of those due to opioid use disorder, another important publication is *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (2015). ASAM developed these guidelines to provide information on evidence-based treatment of opioid use disorder.

Practitioners should also consult the World Health Organization's *Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence In Closed Setting,* and ASAM's *Standards of Care for the Addiction Specialist Physician*. These documents establish minimum standards and performance measures for the treatment of substance use disorders regarding assessment, diagnosis, treatment planning and management, care coordination, and continuing care management. These standards set a minimum level of performance for practitioners and should not be taken as describing the full extent of care that a person with substance use disorders might require.

To help practitioners, ASAM offers a variety of trainings for professionals who work with individuals experiencing substance use disorders, including continuing medical education credits and trainings on the National Practice Guideline, their State of the Art Course in Addiction Medicine, a series of webinars on the National Practice Guidelines that cover individuals with co-occurring psychiatric disorders, pregnant women, individuals in pain, and individuals in the criminal justice system. For more information, see ASAM's e-learning center (https://elearning.asam.org/) or their Quality and Practice section (http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg). Training is also available through the World Health Organization's website (http://whoeducationguidelines.org/).

Priority Needs

Recognizing addiction as a chronic disease of the brain that has biopsychosocial manifestations has

several implications for criminal justice (CJ), especially drug and other problem-solving courts and their operations, policies and procedures:

1. CJ professionals need to understand what addiction is in etiology (that is, its origin or cause); signs and symptoms; and the current state of addiction treatment, which is to utilize a continuum of disease management levels of care and a variety of interventions. This includes the use of all medication treatments for opioid use disorder, including methadone, buprenorphine, and naltrexone.

2. No one treatment model or method is effective for all individuals, and each person's severity of illness and level of function determines the best intensity of service and level of care. Thus, a multidimensional assessment is necessary to drive individualized service plans and determine the site of treatment. Judges and other CJ personnel should therefore mandate assessment by a medical clinician and treatment adherence, not a level of care and length of stay, if sustainable treatment response and change is the desired outcome.

3. Treatment plans, whether they are during incarceration, as conditions of probation/parole, or in drug courts, should always be determined by a trained clinician.

4. To achieve outcomes of increased public safety and decreased crime, policies and procedures need to promote accountable and good faith effort by those mandated for addiction treatment. Court sanctions and incentives need to promote honest treatment effort by the participant focused on sustainable change, rather than passive compliance and "doing time" in a treatment setting. Current sanctions in drug courts frequently focus on punishing flare-ups of addiction (substance use and positive drug screens) rather than sanctioning for lack of good faith effort in treatment. Incentives too often lack the power to effect lasting prosocial behavior change.

5. Rather than "graduation" from drug and other problem solving courts, there is a need to reframe and rethink a participant's efforts in treatment as a "commencement" of continuing addiction recovery.

RECOMMENDATIONS

1. Education and training for CJ professionals on what addiction is in etiology, signs and symptoms and treatment, and how addiction treatment reduces recidivism and fits into criminogenic risk. Training on relevant topics, such as series of webinars on the ASAM National Practice Guidelines, can be found at ASAM's website and SAMHSA's website.

2. Training on the use and application of *The ASAM Criteria*, which offer comprehensive set of guidelines for assessment, service planning, placement, continued stay and discharge of people with addiction, to people in CJ settings and integrating this evidence-based approach into assessment and treatment planning.

3. When mandating justice-involved individuals to addiction treatment, ensure that policies and procedures uphold multidimensional assessment, individualized and outcomes-driven services; and that sanctions and incentives promote accountable participation and sustainable change.

4. Utilize all encounters with the CJ system, including detention in jail, incarceration, and drug court participation, as an opportunity for diagnosis, treatment initiation and linkage to sustainable continuing care for substance use disorder. This assessment and care should be provided by a clinician with expertise in addiction treatment.

5. Ensure treatment within CJ settings meets the community standards of care set by ASAM and the WHO. Individuals with opioid use disorder should have the opportunity to initiate opioid agonist therapy or antagonist therapy as clinically appropriate, and those already on agonist treatment at the time of detention, incarceration, or participation in drug court should be allowed to continue treatment.

The American Society of Addiction Medicine *(ASAM), founded in 1954, is a professional society representing more than 3,700 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction. To advance addiction care, ASAM releases policy statements on issues including: use of naloxone; measures to counteract prescription drug misuse and diversion; and access to medications to treat opioid addiction. ASAM has also been an ACCME-accredited provider of continuing education since 1977, and is a recognized leader in the planning and presentation of educational events. ASAM's educational programs prepare physicians and clinicians to translate the power of science into high-quality services for patients, their families and communities.*

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