Public Policy Statement On Treatment for Prisoners With Addiction to Alcohol or Other Drugs

In April 1994, the American Society of Addiction Medicine (ASAM) adopted a Public Policy Statement on Persons with Alcohol and Other Drug (AOD) Problems and the Criminal Justice System. Recommendations included ASAM support for “…adequate and appropriate AOD treatment for persons who are incarcerated. In addition to primary addiction treatment, there needs to be pre-release planning, post-release continuum of care, and help for the inmate in structuring a healthy post-release social network. [Additionally,] ASAM supports rewards (e.g., return of freedoms) for offenders who successfully participate in treatment and monitoring programs….“ Newer data allows for a description of an evidence-based plan for a care continuum for such individuals, which includes the need for pre-release treatment as well as post-release strategies.

Statistics continue to show that use or misuse of addictive drugs (including alcohol) is involved in over 50% of felonies and is a major factor in criminal recidivism.

Demonstration projects in California, Texas and Delaware have shown that recidivism (defined as return to prison) within three years can decrease by as much as 65% if diagnosed individuals complete a continuum of addiction care. Other studies have shown that coerced treatment is effective. Not only do many addicts have a neurobiological sensitivity to the pharmacological effects of addictive drugs; most are also deficient in the coping skills and decision-making skills necessary to deal with life's difficulties in a healthy manner. Treatment provides education in healthy ways of dealing with life's problems, most of which are unfamiliar to persons with addiction who enter a period of incarceration. The acquisition of new life management skills, as well as skills to maintain abstinence from alcohol and other drugs, can assist most incarcerated addicts in avoiding reversion to their dysfunctional pre-incarceration behavior.

The CALDATA study in California showed that for each dollar spent for treatment, society saves seven dollars in future costs. Other studies have demonstrated the cost savings aspect of investing in the treatment of addiction. These studies do not even consider the non-monetary benefits of treatment, such as the social and psychological benefits to society of reductions in crime. The National Institute on Drug Abuse supported many studies of this type and has published their results. However, this
information does not seem to have received sufficient attention by legislators and other policy makers.

Many physicians caring for prison inmates lack training and experience in diagnosing and treating addiction. Since addictive disease interacts with many other medical illnesses and with a wide range of psycho-social problems, this lack of preparation guarantees inadequate medical care for many prisoners, even though the treating physician may be competent in all aspects except for addictive disease management. In addition, “truth in sentencing” policies in the federal court system and in many states have eliminated parole or other early release options, so that a valuable way to induce prisoners to enter treatment programs is lost.

Pilot programs which incorporate addiction treatment with correctional services have shown that prisoners in a treatment program do much better if they are housed together and work together, separate from the usual prison population and environment. Current policy, however, is that all federal prisoners must work in the same areas, making this sort of therapeutic segregation impossible. Experience in California and Delaware suggests that federal prison treatment programs could improve their efficacy were they to adopt policies that segregate those prisoners receiving active addiction treatment from the general prison population.

Data currently available show that the following modalities and duration of addiction treatment (in each of three phases) result in the lowest reincarceration rates:

1) during the phase of incarceration in prisons or jails for long-term inmates, therapeutic community treatment, for a period of nine to twelve months, is most effective
2) during the immediate post-release phase, residential treatment in a work-release program based in a halfway house, for a period of three to twelve months, is most effective
3) after discharge from such a residential treatment setting, community-based outpatient treatment, for a period of at least twelve months, is most effective.

It should be noted that research has shown that “boot camps” and post-incarceration counseling alone are not effective in reducing re-incarceration rates.

An additional benefit to mandating treatment for prisoners who are addicts is that dropping out of treatment is highly predictive of return to criminal activity and reincarceration; thus, early intervention programs can be developed for those persons who drop out of corrections-sponsored treatment services.

To update previous policy based on current knowledge, ASAM recommends that:

1. All inmates of jails and prisons should be screened for addictive disorders and treatment should be provided for all who are found to be suffering from these disorders;
2. Treatment for substance use disorders should begin during incarceration in prison (pre-release treatment) and should always be followed up by a post-release residential treatment/ work-release program and then by community-based outpatient treatment of appropriate duration;

3. Prisoners receiving pre-release addiction treatment should be housed together in an area segregated from the general prison or jail population;

4. For any prisoner suffering from a substance use disorder, a condition for being released on parole should be the successful completion of the recommended pre-release treatment;

5. For any prisoner who has received pre-release treatment before his or her release to parole, a necessary condition for continuation of parole should be successful participation in and completion of the recommended post-release treatment;

6. All persons who are participating in residential treatment followed by community corrections programs should be housed in corrections-specific halfway houses so as to receive the milieu supports of a substance-free group recovery environment;

7. Physicians and other health care professionals who provide care to inmates and parolees should receive education in the diagnosis and treatment of addictive disorders;

8. Additional sources of funding should be sought for such treatment programming, including funds derived from the confiscation of money and objects involved in the commission of crimes;

9. State and federal legislatures should provide parole or other significant incentives to induce inmates with addiction to enter an appropriate continuum of treatment services.

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