# EFFECTIVE COURT RESPONSES TO PERSONS WITH SUBSTANCE USE DISORDER

## UNDERSTANDING THE PROBLEM: SUBSTANCE USE DISORDER

In 2016 there were more than 63,600 drug overdose deaths in the United States.[1] According to recent reports by the Centers for Disease Control, the age-adjusted rate of drug overdose deaths in the United States is now more than three times the rate it was in 1999.[2] Opioid overdoses make up a significant portion of overdose deaths, with opioids involved in 42,249 deaths in 2016, five times higher than in 1999.[3]

Most people begin using drugs for the first time when they are teenagers, and while drug use is the highest among people in their late teens and twenties, drug use is increasing among people in their fifties and early sixties.[4] For all age groups, however, the rate of drug overdose deaths increased from 1999 to 2016.[5]

There is a strong connection between crime and substance abuse. A Bureau of Justice Statistics survey found that one-third of people in state prisons reported they committed their offense while under the influence of drugs and more than two-thirds had used drugs regularly.[6] The range of crimes committed while using drugs is varied. In 2006, of the 2.3 million people in prisons and jails, alcohol and drugs were involved in 78% of violent crimes; 83% of property crimes; and 77% of public order, immigration or weapon offenses and probation and parole violations.[7] A relationship also exists between substance abuse and involvement in the child welfare system, with substance abuse being present in up to two-thirds of child maltreatment cases.[8]

Treatment needs are also high. In 2016, an estimated 21 million people over age 12 needed substance use treatment, and people who are incarcerated bring this need with them into prison and jail.[9] Well over one-half of all incarcerated individuals have significant substance use problems. Of the 2.3 million people incarcerated in the United States in 2006, 1.5 million met the DSM-IV* medical criteria for alcohol or other drug abuse and addiction; and another 458,000, while not meeting the DSM-IV criteria, had a history of involvement with substances.[10] In a 2004 survey, almost 60% of women in state prisons reported drug use in the month before their arrest.[11] While a large portion of individuals in jails and prisons have substance abuse issues, very few receive treatment. In 2006, only 11% of the 64% of incarcerated persons meeting clinical diagnostic criteria for substance use disorder received treatment.[12]

As part of the development of a curriculum for judges, the National Center for State Courts reviewed the literature and interviewed researchers and practitioners regarding effective court responses to address persons with substance use disorder, including opioid use disorder, at three decision points: pretrial, sentencing, and probation supervision. This brief summarizes seven key conclusions that emerged from the review.

## KEY FINDINGS: ELEMENTS OF EFFECTIVE COURT RESPONSES

1. **Conduct risk, need, and responsivity (RNR) and clinical assessments to determine effective supervision and treatment strategies.**

   Screening and assessment is critical to the effective supervision and treatment of persons with substance use disorder (SUD) in the criminal justice system. Because of the risk of overdose or withdrawal, screening for opioid use disorder (OUD) is particularly important at all decision points, including release from incarceration when tolerance to opioids may have lessened while in custody. For this reason, the use of jail as "treatment" or for detoxication can actually increase the likelihood of terminal overdose.[13]

   Use of RNR screening and assessment tools for all persons with a SUD, including an OUD, is important to identify risk level and other criminogenic risk factors (i.e., "dynamic" or changeable risk factors, such as

** The Diagnostic and Statistical Manual of Mental Disorders (DSM) IV was superseded in 2013 by the DSM-5. Under DSM-5, substance use (or "abuse") and substance dependence are no longer considered separate disorders but have been combined into a single "substance use disorder" (SUD) that measures severity of symptoms on a scale from mild to severe. There are a total of 11 symptoms of substance use disorder: "mild" substance use disorder requires endorsement of 2–3 symptoms out of the 11 symptoms; "moderate" substance use disorder requires the presence of 4-5 symptoms; and "severe" disorder requires 6 or more symptoms. Mild SUD is roughly equivalent to what was formerly called "abuse", while "moderate" and "severe" SUD are roughly equivalent to what was formerly referred to as "dependence" or "addiction."*

anti-social attitudes, anti-social peers, and education/employment deficits. Recidivism can be reduced by successfully addressing criminogenic needs through effective supervision and treatment.[14] Proper risk assessment is also crucial so that low risk persons are placed with other low risk persons for treatment needs, as mixing low risk with high risk persons can have negative outcomes for the low risk persons.[15]

Clinical SUD screening and assessment tools are critical in identifying clinical needs. For SUD screening, the Substance Abuse and Mental Health Services Administration (SAMSHA) recommends use of the Texas Christian University (TCU) Drug Screen 5 (TCUDS 5) or the Simple Screening Instrument (SSI) to screen for symptoms and severity of substance use.[16] The TCUDS 5 also has an opioid screening supplement to identify persons who may need immediate treatment.[17] (The Alcohol Use Identification Test (AUDIT) can be combined with either the TCUDS 5 or the SSI if a more detailed screening for alcohol use is needed.) SAMHSA advises against using the Substance Abuse Subtle Screening Inventory (SASSI).[18]

For SUD assessment, SAMSHA recommends the TCU short forms, e.g., TCUDS 5, TCU Client Evaluation of Self and Treatment (TCU CEST), TCU Mental Trauma and PTSD Screen (TCU TRMA), and TCU Physical and Mental Health Status Screen (TCU HLTH), and/or the TCU Criminal Justice Comprehensive Intake (TCU CJ CI) assessment, which can be used in settings that do not currently utilize a standardized intake instrument and can be combined with other short forms to provide a full assessment.[19]

Many jurisdictions also find it helpful to assess offender motivation. SAMSHA recommends use of the TCU Motivation Form (TCU-MOTForm) or the University of Rhode Island Change Assessment Scale (URICA), which provides efficient identification of readiness to change.[20]

**2. Base interventions on the person's level of criminogenic risk and level of SUD.**

Effective assessment allows supervision agencies to match the person with appropriate interventions.

- High risk drug offenders require intensive supervision, cognitive behavioral therapy, strict monitoring, greater use of rewards and reinforcement in response to pro-social and compliant behaviors, use of swift and certain sanctions in responding to non-compliant and non-responsive behaviors, and substance use treatment services proportionate to the level of SUD. Persons with mild SUD who have the ability to comply should generally receive higher magnitude sanctions for drug use than persons with moderate or severe SUD who often lack that ability. Those with moderate or severe SUD should receive treatment adjustments and low-level sanctions, such as verbal admonishment or curfew.[21]

- Low risk drug offenders require low level, if any, supervision and SUD treatment services proportionate to their level of SUD. Avoid over-supervision and revocations.[22]

For treatment, the American Society of Addiction Medicine-Patient Placement Criteria (ASAM PPC) is a widely-used assessment system that employs patient placement criteria to identify appropriate levels of care for persons with varying levels of SUD.[23] ASAM level of care 1 refers essentially to ordinary out-patient care, level 2 refers to intensive out-patient care, and levels 3 to 5 refer to increasing levels of intensity of residential care.[24]

Flexibility in setting and enforcing conditions of supervision is important. Continuous monitoring of the person's performance on supervision and in treatment and of drug testing results may require modification of the terms and conditions of supervision and treatment and reassignment to a different intervention if appropriate.[25]

**3. Include medication assisted treatment (MAT) in OUD interventions.**

Successful treatment of OUD requires a combination of MAT and other indicated treatment services. Studies find that MAT combined with treatment is more effective than either treatment or medication alone in reducing opioid use and increasing entry into treatment and treatment retention. Naltrexone (see below) has been consistently demonstrated to also reduce re-arrest and re-incarceration.[26]

Although there is some concern about an over-reliance on medication that too often neglects the "treatment" component of MAT, and some judges unfamiliar with the research confirming addiction to be a form of brain disease resist fixing a drug problem with another drug, there is no dispute among experts that proper use of medications is a critical component of OUD treatment.[27] MAT is strongly recommended by the National Association of Drug Court Professionals, for example, and drug courts receiving federal funding must permit use of MAT unless the court finds that the defendant is misusing or diverting use of the medication.[28] Using medications in addressing OUD has been likened to using insulin in the treatment of diabetes or lithium in addressing bi-polar disorders.[29]

The principal medications used in MAT are methadone or buprenorphine (e.g., Suboxone), naltrexone (e.g., XR (extended release) Vivitrol), and naloxone (Narcan). Each has a different purpose.

- *Methadone and buprenorphine (e.g., Suboxone)* are increasingly administered to persons with an opioid addiction both in custody and prior to release to address short-term withdrawal issues. The standard

of care for severely opioid addicted persons is also to use these medications as maintenance, not just detoxication, regimens over average treatment durations of 18 to 24 months.

Methadone is a full-effect, addictive, controlled substance that blocks cravings for other opioids and is used to address withdrawal symptoms and cravings. It is dispensed through federally regulated Opioid Treatment Programs (OTPs) and offered in pill, liquid, and wafer forms.

Buprenorphine is also a controlled substance that blocks cravings for other opioids and serves as an alternative to methadone. Unlike methadone, it can be prescribed outside of a federally regulated treatment program in office-based opioid treatment centers approved by SAMHSA. Prospective providers must complete an 8-hour class to qualify as a provider. "Data-waived doctors" are authorized to prescribe to up to 275 patients. Buprenorphine is typically administered under the tongue and results in less sedation, intoxication or euphoria than heroin, methadone, or other opioids, and has a lower risk of respiratory suppression, overdose or death. It can be combined with naloxone (see below) such that abusing or overdosing on buprenorphine will release naloxone and precipitate withdrawal symptoms.

Neither methadone nor buprenorphine produce any euphoria or intoxication in persons tolerant to opioids but both can be dangerous when used with alcohol or some other drugs such as sedatives. Prescription drug monitoring programs, pill counts, and random drug testing are used to prevent diversion of medications to other individuals.[30]

- *Naltrexone (e.g., XR Vivitrol)* is increasingly first administered after detoxification and before a person's release from jail to avoid the risk of overdose by those whose tolerance to opioids has lessened while in custody.

Naltrexone is not a controlled substance and, according to some studies, blocks cravings and the effects of other opioids and alcohol, but it cannot be administered until the patient fully detoxifies over a period of 7-10 days from the use of other opioids.[31] It can be taken as a daily pill or, more commonly, in XR form as a monthly injection. It must be prescribed and administered by a nurse or pharmacy in a medical setting like flu shots. The pill form cost is about $1 a day and many states cover it in their Medicaid formulary. Vivitrol, the injectable form, is expensive (about $700 to $1,000 per month) and may not be covered by Medicaid, although an increasing number of states are doing so.[32] The injectable form is more effective because patients cannot so easily avoid taking the medication. Naltrexone is almost never misused because it is not intoxicating.

- *Naloxone (Narcan)*, the opioid overdose antidote, is increasingly provided to persons with an opioid history when released from incarceration and is available to law enforcement agencies, health and mental health providers, families, and others who regularly are in contact with people who use opioids.[33]

Naloxone is a prescription medication that temporarily stops the effect of opioids and helps a person start breathing again in 2 to 5 minutes. It can be injected or applied as a nasal spray and lasts for 30 to 90 minutes. In some states the medication can be distributed by pharmacies and community groups through prescription agreements.[34]

In addition to interventions based on RNR and clinical assessments to address risk and need factors as described in #2 and interventions involving MAT, those with OUD may need specialized assistance to address the severity and potential lethality of their addiction. Examples of such assistance are the use of dedicated and specialized probation officers who coordinate with treatment and medical providers, recovery peer support, trauma-informed care, motivation enhancement therapies, and post-residential treatment step-down processes to avoid overdose. Those with OUD should have access to the full continuum of evidence-based treatment services based on ASAM PPC level of care criteria.[35]

4. **Consider whether co-occurring and other needs also require attention.**

   Persons with SUD often have an array of co-occurring needs that may require mental health treatment, trauma-informed care, and peer support recovery services. Criminal thinking interventions, family counseling, and vocational or educational counseling may also require attention.[36] The existence of co-occurring needs may not emerge until later in the course of treatment for SUD, as the effects of SUD may obscure their presence.[37] Therapeutic communities are particularly effective for reducing recidivism for persons with co-occurring disorders.[38]

5. **Use drug court interventions for high-risk persons with moderate to severe SUD.**

   For high risk and high need (moderate and severe SUD) persons, drug courts offer an effective continuum of care for substance abuse treatment including detoxification, residential, sober living, day treatment, intensive outpatient and outpatient services. Standardized patient placement (or treatment matching) criteria such as the ASAM PPC often govern the level of care that is provided. Adjustments to the level of care should be predicated on the participant's response to treatment. Treatment providers should administer behavioral or cognitive-behavioral treatments that are documented in manuals and have been demonstrated to improve outcomes for

persons with addictions involved in the criminal justice system. Treatment providers should be proficient at delivering the appropriate interventions and should be supervised regularly to ensure continuous fidelity to the treatment models.[39]

Although drug courts are an evidence-based practice for high risk and high need persons in the criminal justice system, they can increase recidivism for offenders who are not high risk.[40] A study of adult drug courts in New York also found that drug courts not accepting felony cases had no impact on recidivism and a direct relationship between the percentage of felony offenders in the program and its effectiveness in reducing recidivism.[41]

6. **Include random, unpredictable, and frequent drug testing in the supervision of persons with SUD.**

Random, unpredictable, and frequent drug testing is a best practice standard in the supervision and monitoring of persons with SUD, especially for those with moderate or severe SUD (high need). Because the metabolites of most drugs of abuse are detectable in urine for approximately 2 to 4 days, urine testing for the full range of substances that the person is likely to be using should be performed at least twice per week until participants are in the last phase of the treatment program.[42] It is also a recommended best practice that the collection of specimens be witnessed directly by a trained staff person.[43]

7. **Consider the person's level of SUD when determining consequences for noncompliance.**

- For persons with moderate or severe levels of SUD, compliance with treatment service requirements is the proximal (immediate, short-term) goal of supervision, while abstention is a distal (ultimate, long-term) objective because persons with moderate or severe levels of SUD cannot, because of their addiction, fully abstain immediately.

- For persons with mild levels of SUD, both compliance and abstention are proximal supervision objectives.

Consequences for non-compliant behaviors should be predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification. For goals that are relatively easy for participants to accomplish, such as being truthful or attending counseling sessions, higher magnitude sanctions may be administered after only a few infractions. For goals that may be difficult for participants to accomplish, such as abstaining from substance use or obtaining employment, sanctions should increase progressively in magnitude over successive infractions. Participants should not receive punitive sanctions if they are otherwise compliant with their treatment and supervision requirements but are not responding to their treatment interventions. Under those circumstances, the appropriate course of action is to reassess the individual and adjust the treatment plan accordingly. Unless a participant poses an immediate risk to public safety, jail sanctions should be administered only after less severe consequences have been ineffective at deterring infractions. Jail sanctions should be definite in duration and typically last no more than three to five days.[44]

## ABOUT THIS BRIEF

This brief was created with support from the John D. and Catherine T. MacArthur Foundation as part of the Safety and Justice Challenge, which seeks to reduce over-incarceration by changing the way America thinks about and uses jails. The Safety and Justice Challenge supports a network of competitively selected local jurisdictions committed to identifying and addressing local drivers of over-incarceration to improve the justice system as a whole. More information is available at www.SafetyandJusticeChallenge.org.

This brief was authored by Judge Roger K. Warren (Ret.) in collaboration with Ms. Sara Ward-Cassady, and Dr. Pamela Casey as part of the National Center for State Courts' work on the Safety and Justice Challenge. The authors gratefully acknowledge Dr. Douglas B. Marlowe, Chief of Science, Law & Policy, National Association of Drug Court Professionals, and Dr. Fred Cheesman, Principal Court Research Consultant, and Ms. Michelle White, Principal Court Management Consultant, both of the National Center for State Courts for their helpful information and suggestions in preparing this brief. For more information on the NCSC's work on the Safety and Justice Challenge, including additional briefs and a curriculum on evidence-based sentencing practices for judges hearing cases involving potential jail incarceration, see http://www.ncsc.org/Topics/Criminal/Courts-and-Jails/Safety-and-Justice-Challenge.aspx. Points of view or opinions expressed in the brief are those of the authors and do not necessarily represent the official position of the MacArthur Foundation or the National Center for State Courts.

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Supported by the John D. and Catherine T. MacArthur Foundation

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## ENDNOTES

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