

## Drug and Alcohol Problems in the Criminal Justice System

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The American Medical Association's initiative to improve health care of inmates of American jails and prisons<sup>1</sup> includes a specific attempt to improve diagnosis, treatment, and rehabilitation of inmates having drug and/or alcohol problems.\*\* The number of inmates with these problems is substantial. Some estimate that perhaps half or more of all prisoners in the jails and prisons of the United States have histories of drug and/or alcohol abuse<sup>2</sup> but broadscale epidemiologic studies of the real prevalence of these problems have not been carried out.

Those arrested for drug sales or possession cannot be assumed to be abusers, although epidemiologic studies by our group at the University of Chicago indicate that most lower level dealers of heroin probably are addicted.<sup>3</sup> National crime statistics indicate that drug sales form a significant percentage of arrests, and alcohol and/or drug influenced behaviors also are important from the point of view of numbers of people arrested.<sup>4</sup> It seems safe to state, therefore, that drug and/or alcohol related problems are among the most important health problems of those persons coming into contact with the criminal justice system either as arrestees, or inmates of the jails and prisons, or as parolees.

I base my approach to these problems on the concept that the criminal justice system as a whole needs to be examined for its relevance to health. Effective care for drug and alcohol problems implies pre and post jail, and pre and post prison programs, as well as accurate early identification of persons with these problems. The arresting officer, then, is an important vehicle for proper routing of persons with drug and/or alcohol problems. Such a perspective recognizes that in many ways an arrest "on the street" is a health related event as well as an event with legal significance. There are, of course, implications for training and for role performance of police officers. This perspective also recognizes the unique needs of the person who has "paid his debt" and is being returned to society.

Obviously this perspective is ideal. One could say with considerable justification that the provision of regular sick call in some of our jails and prisons would be an enormous step forward. Implementation of a system wide definition of health needs obviously requires social, political, and cultural changes which will not come about soon or easily. But defining

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appropriate health standards is necessary if the criminal justice system is to develop the resources and move to reduce the many problems associated with our attempts to respond to criminal persons in our society.

One can and should question whether or not prisoners would use drug and alcohol treatment programs if they were available. I see little to suggest that substantial numbers of them do not want treatment if one considers the problem longitudinally rather than at one point in time. When treatment is available and acceptable from cultural and economic points of view, most addicts use it. In Illinois 26,000 drug abusers have come to treatment in the past ten years. In the Pontiac Prison drug abuse project sponsored by the Dangerous Drugs Commission of the State of Illinois, utilization rates of programs offered to prisoners have been maximal. Many more prisoners want the program than can be accommodated.

It should be mentioned that use of drugs and alcohol seems to be increasing in our society so that there is reason to suspect that the numbers of people who have drug or alcohol problems will increase in coming decades, and this will no doubt be reflected in greater needs for proper response to these problems on the part of the criminal justice system.

I will discuss prison and jail standards for diagnosis, treatment, and rehabilitation of drug and/or alcohol problems first because from a practical point of view, it is the first component of the criminal justice system which we are liable to effect.

Before proceeding I would like to suggest some basic definitions:

Alcoholism is a chronic progressive disease of unknown etiology characterized by repetitive and/or compulsive use of alcohol that interferes with the patient's health and/or adaptation to life. Repetitive and/or compulsive use of alcohol is often but not always accompanied by the development of tolerance, physical dependence, and the withdrawal syndrome.

Drug abuse is characterized by repetitive and/or compulsive use of drugs that interferes with the patient's health and/or adaptation to life. Repetitive and/or compulsive drug use is often but not always accompanied by the development of tolerance, physical dependence, and the withdrawal syndrome.

Drug abuse may also refer to episodic use of unusually high doses, or use in settings not conducive to control, with the result that the patient's psychological and/or biological stability is threatened.

The first element in good care is thorough examination. In this regard, medical screening should be carried out on admission to a jail or prison. This screening should be under the supervision of a licensed physician, and the persons performing the screening procedures should be trained to identify drug and alcohol problems and to refer them for definitive diagnosis and treatment.

Screening instruments used to date have not inquired sufficiently into the use of drugs and alcohol, and persons carrying out medical screening, including physicians, frequently have not been properly trained in obtaining a drug or alcohol history. Frequently drug and/or alcohol abusing prisoners do not know medical jargon, and medical persons do not know street drug jargon. Training standards need to be created to remedy this problem. There

is no reason for prisoners to die, as they sometimes do, in drug and/or alcohol withdrawal because their tremulousness, needle tracks, agitated behavior, etc. have not been detected by admitting officers.

Newer drugs, such as the benzodiazepines, have delayed onset of withdrawal in comparison to older drugs with which medical jail personnel might be familiar. So there is need for careful history taking with respect to these drugs. Frequently people "on the street" do not know that abuse of these drugs can lead to convulsions after incarceration. The point illustrates the need for continuing training and for some mechanism for periodic review of training standards.

Adequate screening should include the items below. In my opinion the italicized items should be added to existing standards.

1. Inquiry about current illnesses and health problems, including those specific to women.
2. Inquiry about medications taken and special health requirements.
3. *Inquiry into the use of alcohol and/or other drugs, which includes types of drugs used, mode of use, amounts used, frequency of use, date or time of last use, and a history of problems which may have occurred after ceasing daily or near daily use (e.g., convulsions).*
4. Screening of other health problems designated by the responsible physician.
5. Behavioral observation, which includes state of consciousness, mental status, *appearance, conduct, tremor, and sweating.*
6. Notation of body deformities, trauma markings, bruises, lesions, ease of movement, jaundice, etc.
7. Condition of skin and body orifices, including rashes and infestations, *and observation of whether old or fresh needle tracks or other cutaneous sequelae of drug abuse are present.*
8. Disposition/referral of inmates to qualified medical personnel on an emergency basis *which includes the assessment of whether the new inmate is in need of detoxification treatment for alcohol and/or other drug dependency.*

Drug abuse and alcoholism problems are changing. These problems do not have the stability of problems like tuberculosis or schizophrenia. The young person of today is a polydrug user, and his use pattern includes alcohol. It is unlikely that he will develop either drug or alcohol problems in the sense of using one or the other class of drugs.

There is substantial data to suggest that the division of "alcoholism" and "drug abuse" is rapidly becoming a matter of history which is not relevant for health care of persons coming into contact with the criminal justice system. The appearance of new substances such as phencyclidine "PCP" presents new problems in diagnosis and treatment.

### Diagnosis

Ideally diagnosis in the chemically dependent inmate is performed by a physician. The diagnosis should be based upon the physician's clinical judgment. The results of laboratory tests do not substitute for this judgment. A urine positive for morphine, for example, is not equivalent to a clinical diagnosis.

Tentative assessment can be made by personnel trained in chemical dependency, functioning under medical supervision.

### **Treatment**

Any institution should have a written standard operating procedure (SOP), approved by the responsible physician, expressing a coherent philosophy and medical guidelines for the treatment of alcoholism, other drug abuse, and opioid dependence. This SOP should provide for extended periods of observation and treatment in hospital settings in instances where there is dependence on opioids, sedative-hypnotics, and/or dependence on alcohol. The SOP should provide for referral for extended care when appropriate. In general the SOP should be structured around the following principles:

1. The physician or his designate is responsible for deciding whether an individual suspected of having a chemical dependency problem requires non-pharmacologically or pharmacologically supported detoxification.
2. An appropriate pharmacologic and/or social environment support regimen is indicated when there is unquestionable evidence that substantial physiologic dependence on alcohol, opioids or sedative-hypnotic drugs exists.
3. The physician or his designate is responsible for the development and implementation of a treatment plan. The clinical aspects of the treatment plan are implemented only by qualified medical personnel.
4. The treatment plan is individualized and based on assessment of the individual patient's needs, and includes a statement of the short term and long term goals that the plan will achieve and the methods by which the goals will be achieved. The individual treatment plan identifies the roles and responsibilities of treatment personnel.
5. When clinically indicated, the treatment plan provides inmates with:
  - a. Access to a range of supportive and rehabilitation services which includes counseling (individual or group counseling and/or self-help groups, such as Alcoholics Anonymous, Narcotics Anonymous or others that the responsible physician deems appropriate).
  - b. Psychotropic medications.
  - c. Referral to community resources.
6. The medical record reflects a physician's periodic monitoring and review of the progress of the case and reflects the physician's responsibility for the disposition of the case.
7. A documented list of approved community resources is available to the facility's treatment personnel. The facility and existing community resources have a contract or letter of agreement describing their relationship. This contract or letter of agreement is updated on at least a biennial basis.
8. The physician or his designate reviews all admissions to the facility for evidence of chemical dependency.
9. Physicians' designates may include: Nurse Practitioners, Physician's Assistants, Registered Nurses, Licensed Practical Nurses, Certified Alcoholism Counselors, Substance Abuse Counselors, and/or Drug Dependence Counselors.

10. Upon request, the physician or his designate is provided with access to all information available on the inmate so that he can determine what portion of that information is relevant to the subject's health. This information may include the nature of drugs the inmate had in his possession at the time of arrest, blood alcohol level, behavior, etc.
11. Persons entering the jails and prisons who are on legal narcotic substitutes such as methadone need to continue to receive narcotics. This poses considerable logistic problems for many prisons and jails where understaffing and lack of training make implementations of ideal standards difficult. But there can be no question of what the standard should be from legal, medical, and ethical points of view. If a person needs a certain treatment in ordinary life, he ought to have every right to receive the same treatment when incarcerated.
12. The person being admitted to a jail or prison who needs referral for treatment of withdrawal should be able to be referred to a community facility or to an in-house facility in the jail or prison. This facility should not practice "cold turkey detoxification," and its standards should compare to those laid down for the jails and prison by the AMA.
13. The inhouse program in jail or prison should have written agreements with community agencies to provide for services which cannot be supplied in the inhouse program.

### **Detoxification**

In order to be accredited, a facility should have a written policy on detoxification. This policy should provide a) for medical supervision of all health related procedures and policies, b) provision for decreasing doses of narcotics for detoxification of narcotics addicts unless an addict wants it otherwise, *i.e.*, cold turkey regimens should be explicitly rejected as inhuman and ineffective, c) the creation of training programs for all concerned with attention to the need for continuing revision of training goals on an annual or semi-annual basis, d) written agreements with community agencies and/or consultants as necessary to provide basic services.

A working definition of detoxification is as follows: Detoxification is the process by which an individual who is physically and/or psychologically dependent upon a drug is brought to a drug-free state. In the event that physical dependence is present, detoxification refers to the process by which an individual is gradually withdrawn from the drug by administering decreasing doses either of the same drug upon which the person is physically dependent or one that is cross-tolerant to it, or a drug which has been demonstrated to be effective on the basis of medical research. If an inmate is opioid dependent in mild degree, the withdrawal syndrome may respond to situational control and minor tranquilizers. But if opioid dependence is moderate or severe, usually opioid drugs or drugs whose effectiveness has been demonstrated will be required. The purpose is to prevent the pain, discomfort, and possible danger that can result from abrupt termination of a drug upon which the patient had developed a physical dependence. Detoxification from some drugs (*e.g.*, amphetamines and cocaine) may sometimes require the use of drugs which are not cross-tolerant (*e.g.*, the use of valium in an amphetamine dependent individual who is ceasing

amphetamine use under medical supervision). Detoxification in alcohol dependent individuals does not involve administering decreasing doses of alcohol; it does involve administering decreasing doses of drugs which are cross-tolerant to alcohol.

With close monitoring, detoxification from many drugs of dependence could be carried out on cell blocks, but for accreditation the facility should be able to demonstrate that medical personnel have access to inmates on whatever basis is necessary for administration of the withdrawal regimen. The detoxification program should recognize and implement non-pharmacologic components such as access to medical personnel and groups for psychological support and counseling.

### **The Special Patient**

Penal institutions seeking accreditation should have written policies and programs to respond to the needs of special populations such as pregnant addicts, juveniles, severely disturbed psychiatric conditions which are concurrent with drug abuse or alcoholism, and inmates with drug abuse and alcoholism concurrent with severe medical problems.

An SOP approved by the responsible physician recognizes the population of the drug and alcohol dependent persons with special needs, such as psychotic disorders, pregnancy, juvenile offenders, etc.

The SOP recognizes that pregnancy poses a special risk for chemically dependent pregnant women. Detoxification of pregnant, opioid dependent inmates should be carried out very cautiously, if at all.

Pregnant women with physiological dependence on alcohol and/or other drugs are detoxified only in a medical setting.

### **Confidentiality**

With respect to confidentiality I suggest the following: Access to medical record should be controlled by the responsible physician. The principles of confidentiality apply to the medical record, and their use for purposes of prosecution or institutional control should be banned by specific institutional policies. The principle of confidentiality protects the patient from disclosure of confidences entrusted to a physician during the course of treatment. *All information gathered and recorded about alcohol and drug abuse patients is confidential under federal law and cannot be disclosed without written consent of the patient or the patient's parent or guardian.*

### **Medical Records**

For accreditation, medical records should contain the completed receiving screening form, health appraisal data collection forms, all findings, diagnoses, treatments, dispositions, prescriptions and administration of medications, notes concerning patient education, written authorization for release of information forms, informed consent forms, notations of place, date and time of medical encounters, and terminations of treatment from long term or serious medical or psychiatric treatment. The method of recording entries in the medical record, and the form and format of the record, are approved by the responsible physician.

There is no question that the foregoing suggested standards are simply

not implementable by many jails and prisons. But they represent goals toward which the system should move. There are facilities which meet and exceed these standards, so the system can be thought of as a continuum with varying ability to achieve these goals.

Ideally, prisoners should have in-house programs focused on substance abuse, including nicotine. These programs should have strong links with post release programs which provide for the many supports needed by prisoners in the difficult post release period.

One of these needs is, of course, to have social contacts free of pressure to use illicit drugs. We have a growing experience with this concept. In Illinois the DART program sponsored by the Illinois Department of Corrections and the Community Corrections Drug Abuse Program represent such attempts.

The perspective which recognizes the major health aspects of the arrest event is embodied in the national experience with TASC (Treatment Alternatives to Street Crime) and in model programs such as the Montgomery County, Pennsylvania, MCES (Montgomery County Emergency Service) program. The latter program provides for medical and psychiatric screening at the point of arrest and represents a step toward providing adequate substance abuse diagnosis and treatment and integration of such data into the legal process.

In closing, I would like to comment again on the present discrepancy between ideal standards and the fiscal and administrative realities for many institutions. They are there; they are relevant, but they should not deter us from attempting to move to improve the care of persons in our criminal justice system.

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