



**ASAM** American Society of  
Addiction Medicine

## **Public Policy Statement on Access to Medications for Addiction Treatment for Persons Under Community Correctional Control**

### **Background**

Individuals under community correctional control include those on probation or parole. People on probation may have been sentenced to a term of supervision in the community or may be serving their sentence in the community in lieu of incarceration, the latter of which includes those involved with problem-solving courts such as drug courts, mental health courts, and veterans' courts, among others. Parole is a form of community correctional control for people who are conditionally released from a state correctional institution who are serving the remaining portion of their sentence in the community or those who are required to serve a term of supervision in the community upon release from a state correctional institution.

Rates of substance use disorders among those on probation or parole are significantly and consistently higher than those of the general population,<sup>1</sup> and the risk of opioid overdose is considerably higher for persons on probation or parole than for the general population.<sup>2</sup>

Many people under community correctional control do not have access to evidence-based addiction treatment, including Food and Drug Administration (FDA)-approved medications for opioid use disorder (MOUD) (methadone, buprenorphine, and naltrexone). All three of these medications are effective in reducing illicit opioid use and increasing retention in care compared to treatment without MOUD.<sup>3</sup> A review of the peer-reviewed literature on the effectiveness of these three medications for opioid addiction among adults under community correctional control concluded that reasonable evidence exists that illicit opioid use and self-reported criminal behavior decline after treatment entry.<sup>4</sup> However, the review noted that there is no conclusive evidence regarding the extent to which pharmacotherapy impacts the likelihood of arrest and incarceration among individuals under community correctional control, likely due to the complex nature of policing and the impact of community correctional control on likelihood of arrest. Notably, only methadone and buprenorphine treatment are associated with reduced likelihood of overdose death,<sup>5</sup> including lower mortality for individuals under community correctional control.<sup>6</sup> FDA-approved medications also exist for the treatment of alcohol use disorder (disulfiram, acamprosate, naltrexone) and tobacco use disorder (nicotine replacement therapies, bupropion and varenicline). In many places, court orders and correctional organization policies may limit

access to treatment options,<sup>7,8,9</sup> particularly agonist MOUD (methadone or buprenorphine),<sup>10</sup> despite the fact that these are essential treatments.<sup>3, 11, 12,13, 14</sup> MOUD are also underutilized in treatment courts,<sup>15</sup> despite a federal requirement that all drug courts receiving federal money permit medication treatment.<sup>16</sup> Best practice recommendations from the National Association of Drug Court Professionals advise courts to grant access to addiction medications when recommended by a prescriber.<sup>17</sup> Policies that prohibit access to medication treatment can violate federal anti-discrimination law protecting individuals with disabilities.<sup>18</sup>

At the end of 2018, drug crimes were the most serious offense for 26 percent of people on probation and 30 percent of people on parole.<sup>19</sup> Black men are five times more likely to be arrested for drug-related charges as compared to white men, despite similar rates of substance use,<sup>20</sup> and Black adults are about 3.5 times as likely as whites to be on probation or parole.<sup>21</sup> Effective SUD treatment, including MOUD, is key to preventing relapse, probation/parole technical violations, and recidivism, and – most importantly – overdose and death.<sup>3, 11</sup> Still, only an estimated 1 in 20 criminal-legal referred individuals with OUD are referred for MOUD<sup>22</sup> and significant racial disparities in access to MOUD exist, with Black patients being significantly less likely to receive buprenorphine in an office-based setting than white patients.<sup>23</sup>

Although addiction is a treatable, chronic, relapsing disease, individuals under community correctional control who are unable to remain abstinent may face sanctions, which can include probation revocation or incarceration.<sup>24</sup> A 2019 report by the Council of State Governments revealed technical violations, such as having a positive drug test, account for almost one in four admissions to state prison.<sup>25</sup> Drug testing (toxicology) interpretation is complex, and standard presumptive tests frequently used in community correctional control can have high rates of false positive results (meaning the test reads as positive but it actually is not). Findings should not be deemed as 100% accurate. Definitive testing (gas or liquid chromatography combined with mass spectrometry) is recommended when the results will inform a decision with major implications for the patient,<sup>26</sup> such as the decision to penalize or reincarcerate a patient under correctional control.

Linkages between community correctional control agencies and community addiction treatment providers can help improve treatment referral rates and probation and parole staff knowledge and perceptions related to addiction treatment options.<sup>27</sup> Better linkages to community addiction treatment programs that offer pharmacotherapy might help improve low rates of MOUD access among individuals under community correctional control.<sup>28</sup>

## Recommendations

The American Society of Addiction Medicine recommends:

1. All persons under community correctional control should have equitable access to evidence-based treatment for substance use disorder (SUD), including all FDA-approved medications available in the community or via telehealth. Treatment decisions should be made collaboratively between the patient and their healthcare provider(s). Judges and probation/parole officers should not make specific treatment recommendations or mandate or prohibit any particular type of treatment or peer support, but instead should know how to help patients identify and connect with local SUD treatment providers. Treatment is most

likely to be successful when patients have a choice and provide informed consent regarding the type of behavioral and medication treatment(s) they engage in. Patients should be able to accept or decline any particular treatment, and they should be able to stop treatment if they wish.

2. Areas without sufficient access to all forms of treatment should explore telehealth options and coordinate with local public health and state treatment authorities to support treatment expansion.
3. Persons who are charged with or convicted of crimes related to their SUD should be offered, where appropriate, treatment rather than punishment.
4. Persons with SUD under community correctional control should receive comprehensive case management. Assessments should factor in their resources and needs such as housing, transportation, employment, health insurance and childcare. Community correctional control agencies should maintain relationships with community-based organizations that facilitate access to affordable housing resources, food, health insurance and health care (including mental health care), and other social supports.
5. Legal decisions should never be based on results from rapid, presumptive tests that have not been confirmed by patient report and/or through the use of definitive testing methods (gas or liquid chromatography combined with mass spectrometry).<sup>26</sup> Definitive testing (gas or liquid chromatography combined with mass spectrometry) should be required before individuals under community correctional control are given a violation or incarcerated based on a presumptive test result. Making decisions without definitive testing can mean unfairly incarcerating a person based on misleading, if not wrong, results.
6. Addiction is a treatable, chronic medical disease, and resumed drug use should be met with additional support as opposed to more punitive measures when possible. Persons with addiction should be given time to engage in treatment and enter recovery, with progress toward those ends measured incrementally (i.e., through participation in treatment, work, or family activities rather than solely through drug testing results).
7. All community correctional control officers should be trained to recognize the signs and symptoms of an opioid overdose and to use naloxone to reverse an overdose and save a life. Community correctional control agencies should provide overdose recognition and response training to all interested persons under community correctional control, have naloxone available for distribution as needed, and share information about relevant Good Samaritan laws.<sup>29</sup>
8. Judges, probation and parole officers, and other staff who work with people under community correctional control should receive education and training on the science of addiction; evidence-based addiction treatment including medications; stigma reduction; and trauma-informed services. This training includes recognition of addiction as a treatable, chronic medical disease.<sup>30</sup> They should also be educated about the role racial and other biases may play in treatment choices, drug testing, and responses to relapses.
9. All community correctional control referrals should be to programs (both outpatient and inpatient) offering evidence-based addiction treatment, including behavioral treatments and all FDA-approved medications as available locally or via telehealth. Judges, probation officers, and parole officers should cultivate relationships with a variety of local treatment providers to ensure access to all forms of evidence-based treatment, including opioid treatment programs (which offer methadone and often buprenorphine and naltrexone) and office-based or other addiction treatment providers (which offer buprenorphine or naltrexone treatment).
10. Addiction treatment professionals should receive education about the purpose, role, and requirements of community correctional control agencies. Addiction treatment agencies

should, when possible, develop relationships with community correctional control agencies to support connections to treatment.

11. Addiction treatment professionals should advocate for access to evidence-based treatment and recovery resources for patients under community correctional control.<sup>31</sup>
12. The “inmate exclusion” that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons should be repealed and the inmate limitation on benefits under Medicare should be removed. Continuation of healthcare coverage during detention and incarceration will facilitate treatment continuity and retention, possibly with the same addiction treatment provider.
13. Additional research is needed to assess the effects of probation, parole, and problem-solving court policies on participants. Recidivism, substance use, mortality rates, and other community outcomes, including costs and local crime rates, should be investigated scientifically. The impact of access to evidence-based treatment on these populations, as well as any inequities related to race/ethnicity or geographic region of the country, should also be investigated.

***Adopted by the ASAM Board of Directors January 20, 2021, reaffirmed on September 14, 2025 through January 20, 2031.***

*This policy statement is endorsed by the National Association of Drug Court Professionals and the American Probation and Parole Association.*



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