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A New Path for Public Policy: A Roadmap for Smarter and More Effective National Alcohol and Drug Policies

Alcohol and drug addiction is a preventable and treatable disease – just like cancer, diabetes, and heart disease. People with addictions can recover and have a meaningful life in the community – if they get the help they need.

For over a decade, addiction treatment has been shown to cut alcohol and drug use in ***half***, reduce crime by ***80 percent*** and arrests by up to ***64 percent***, and has a proven impact on HIV risk behaviors and incidence of HIV infection. Addiction treatment results also are sustainable – studies have found that, one year after completion of treatment, there is a 67% reduction in weekly cocaine use, a 65% reduction in weekly heroin use, a 52% decrease in heavy alcohol use, a 61% reduction in illegal activity, and a 46% decrease in suicidal ideation. Moreover, these outcomes are generally stable for the same clients five years post treatment.[i] And taxpayers ***save $7 for every $1*** spent on treatment and ***$5.60 for every $1*** spent on prevention, as a result of increased productivity, and reduced health care, criminal justice, welfare and social costs. When adding the savings to healthcare, for every $1 dollar spent on addiction treatment, ***society benefits by more than $12***.[ii]

However, while addiction afflicts one in ten Americans and affects one of every four children, only ***11% of the 23.6 million*** people who need treatment for alcohol and drug problems receive it. Additionally, millions of young people never benefit from proven prevention strategies that are successful and cost-effective – a Washington state study of school-based prevention programs found that a number of prevention programs resulted in a ***$70.34 benefit for each dollar spent*** for each participating young person.

Finally, individuals in recovery often are discriminated against as they seek employment, insurance, and other necessities of life. This failure to effectively integrate addiction prevention, treatment and recovery into our nation's health care structure is ***costing over 100,000 lives*** and ***more than a third of a trillion dollars annually***, harming families and communities across the country.

America must adopt health policy reform that will save tens of thousands of lives as well as billions of dollars – and strengthen families and communities across the country – with two important steps:

*** <u>Expand and Improve Health Responses to Addiction</u>: Include Equitable and Adequate Treatment and Recovery Support in All Public and Private Health Care Plans and Promote Prevention, Early Intervention, Recovery, and Research. Begin with the immediate expansion of drug and alcohol treatment services for an additional one million individuals.**

*** <u>Eliminate Discrimination Against People in Recovery</u>: Repeal Discriminatory Laws and Policies.**

Five Key Principles

(1) **Science Has Proven That Addiction Is A Preventable and Treatable Disease:** The American Medical Association, National Institutes of Health, and other leading health authorities have conclusively pronounced that alcohol and drug addiction is a preventable and treatable disease. Scientific research has made astounding breakthroughs in understanding the nature and impact of addiction and clearly establishing the effectiveness and cost benefits of quality treatment and prevention. This science should drive alcohol and drug policy.

(2) **Equitable and Adequate Addiction Prevention And Care Is Integral To Success of Health Care Reform, But Funding To Reduce Demand Has Fallen Far Behind:** Health responses to addiction – prevention, treatment, and recovery strategies – should be widely available and included in all health care plans and reform. Additionally, these services should be integrated into other systems including criminal justice, child welfare and housing.

(3) **Prevention, Treatment, and Recovery Support For All Who Need Them:** Every family and community is affected by alcohol and drug addiction. Every child needs alcohol and drug prevention services and organized communities that can strengthen prevention strategies. Everyone in need of treatment and recovery support services should have access to care.

(4) **Treatment Not Prison:** Because of "mandatory minimum" laws that require prison sentences, too often addicted individuals convicted of non-violent crimes are incarcerated even when mandated treatment would be more appropriate and effective in protecting public safety. This "over-incarceration" of addicted persons who instead should be in treatment wastes huge amounts of money and harms families and communities. It has a particularly harsh impact on African-Americans and Latinos, who are incarcerated for drug offenses at much greater rates even though their rates of drug use are comparable to that of whites.

(5) **End Discrimination:** People in recovery or still suffering from addiction encounter widespread discrimination based on addiction history and/or criminal history (often incurred while addicted). Ending this discrimination would help to connect individuals to essential resources that speed the road to recovery.

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Policy Reform Recommendations

I. EXPAND AND IMPROVE HEALTH RESPONSES TO ADDICTION

A. Ensure that equitable and adequate alcohol and drug treatment and recovery support are an integral part of the health care system, including in national and state health care reform initiatives.

1. Increase access to drug and alcohol treatment and recovery services by expanding access to public funding, including the Medicaid program, as well as by ensuring that the private sector does its fair share through equal, non-discriminatory insurance coverage of addiction treatment.

Programs that serve individuals with alcohol and drug addiction depend nearly exclusively on public funds from a variety of programs, including the federal Substance Abuse Prevention and Treatment Block Grant, federal discretionary grant programs, Medicaid, and state funding. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) recent National Expenditure Report, public funding provides the vast majority of addiction treatment expenditures, increasing from 62 percent in 1991 to 76 percent in 2001. Private insurance represented only ***13 percent*** of addiction treatment expenditures in 2001, while it covered almost 3 times as many health care expenditures for other health problems – 36 percent.

Although the alcohol and drug addiction treatment and recovery system relies heavily on public funds, an extremely small percentage of overall health care spending is used for drug and alcohol treatment and recovery services. In 2001, of the $1.4 trillion spent on health care, it is estimated that only $18 billion was devoted to treatment of alcohol and drug addiction – just 1.3 percent of all health care spending and a fraction of the economic and social costs of substance use and addiction, estimated in 1998 to total $328 billion. These costs include medical consequences, lost earnings linked to premature death, lost productivity, motor vehicle crashes, crime, and other social consequences. Given these expenditures, it is not surprising that in 2006 ***21.1 million (89%)*** of the 23.6 million Americans in need of alcohol and drug services ***did not receive any care***.

It also can be especially difficult for special populations, such as women, adolescents and veterans, to obtain necessary drug and alcohol treatment and recovery support services. For example, according to SAMHSA, in 2002 an estimated 2 million veterans were dependent on or abusing alcohol or illicit drugs. However, funding for healthcare services through the VA has significantly decreased. According to the VA Committee on the Care of Veterans with Serious Mental Illness, VA spending on addiction and mental health services declined by 8 percent between 1998 and 2004, and by 25 percent when adjusted for inflation. This decrease in funding has forced the VA to cut back on services for veterans – in 2002, ***less than 20 percent of veterans*** received needed addiction treatment. With hundreds of thousands of American soldiers and sailors currently on active duty in Afghanistan, Iraq and other areas of conflict, it is expected that the need for alcohol and other drug addiction treatment services for veterans will increase significantly.

For individuals receiving care outside of the Veterans Administration, the major public and private programs that make up the vast majority of financial support for drug and alcohol treatment and support services include:

<u>Substance Abuse Prevention and Treatment (SAPT) Block Grant</u>

The foundation for the publicly supported prevention and treatment system in the U.S. is the Substance Abuse Prevention and Treatment (SAPT) Block Grant. SAMHSA's most recent data indicates that the SAPT Block Grant serves nearly 2 million people every year and that it provides roughly half of all public funding for treatment services. Over 10,500 community-based organizations receive federal Block Grant funding, which is passed on to them by their state governments. States receiving SAPT Block Grant funds also are required to contribute state funding for treatment, and many local governments do the same. The Block Grant also provides crucial support for prevention programs, requiring states to designate 20 percent of their total SAPT Block Grant funding for this purpose.

Increasing the overall funding for the SAPT Block Grant, federally funded now at approximately $1.8 billion, could help to support the overall expansion of national access to drug and alcohol treatment and prevention services.

<u>Medicaid</u>

The Medicaid program, while financing very little drug and alcohol treatment in most states, provides other important health care services for eligible populations, including low–income women and children. Many low-income individuals, including all women on welfare and those in families involved in the child welfare system, are eligible for Medicaid. Programs specializing in serving women and their families sometimes receive funding from the Medicaid program.

However, Medicaid coverage for alcohol and drug treatment services is unnecessarily limited and should be enhanced by:

- ***Making alcohol and drug treatment a required service under the Medicaid program.***

  Medicaid finances some drug and alcohol treatment, subject to state limits on amount, duration, and scope, but alcohol and drug treatment is not a required service under the program. Because it is an optional service, only about 25 States have opted to cover drug and alcohol treatment services under their Medicaid benefit, and the level and amount of that coverage varies widely. States providing treatment to Medicaid clients can receive reimbursement if the treatment is provided under a Medicaid service category that qualifies for Federal matching funds. The advantage of this policy change is that it would establish a more stable source of funding for treatment that is not discretionary and subject to the annual appropriations process. Such stability would increase access to treatment for low-income individuals and families who presently rely on limited Substance Abuse Prevention and Treatment Block Grant and scarce discretionary funds to support treatment services.

- ***Lifting the "IMD exclusion" for residential drug and alcohol treatment programs***

  One of the most serious roadblocks preventing individuals receiving Medicaid from obtaining residential alcohol and drug treatment has been the "Institution for Mental Diseases (IMD)

exclusion." The IMD exclusion is a statutory provision that prohibits Medicaid from paying for institutional treatment for individuals between 22 and 64 who are diagnosed with mental diseases and receiving treatment in programs with more than 16 treatment beds. While the purpose of the IMD exclusion – to prevent Medicaid funds from going to expensive mental hospitals – is wholly unrelated to cost-effective, community-based alcohol and drug residential programs, nonetheless the federal government has applied it to deny those programs access to Medicaid funding. Therefore, in order for drug and alcohol treatment programs to receive Medicaid reimbursement, they must keep their residential programs at 16 beds or less.

Additionally, individuals who enter IMD's lose their Medicaid eligibility for all Medicaid reimbursable services, including prenatal and HIV care – costly services which can drain scarce treatment funding if a program forgoes Medicaid funding by running a residential program larger than 16 beds or if it is located in one of the approximately 25 states that does not cover alcohol and drug treatment services under its Medicaid benefit.

Therefore, excluding residential drug and alcohol treatment programs from the definition of Institutions for Mental Diseases under the Medicaid program would provide a source of additional and steady funding for critical residential programs that treat both individuals and families.

Private Insurance

Addiction is a chronic disease, like diabetes, asthma or hypertension, and paying for its treatment yields as good a return as paying for treatment for other chronic illnesses. In 2004, of the 20.3 million adults classified with substance dependence or abuse, 77.6 percent (15.7 million) were employed either full or part time. Yet the number of Americans with employer-provided insurance coverage for alcohol and drug addiction is restricted by day and visit limits, annual and lifetime expenditure limits, and cost-sharing requirements not imposed on other illnesses. These limits – combined with the reality that alcohol and drug addiction is a chronic, relapsing condition – mean that individuals quickly exhaust their insurance coverage for treatment.

When individuals do have benefits, many cannot obtain access to the type, level, or duration of care they need because of inappropriate managed care practices that deny that access to necessary services. Almost half (44.4 percent) of the individuals who made an effort to receive treatment but were unable to, reported that the cost and/or health insurance barriers prevented them from gaining access to treatment.

When privately insured individuals exhaust or are unable to access their benefits, they turn to the public sector for treatment, which increases costs to federal, state, and local governments. Given the lack of funding for treatment and the extent of the addiction problem, achieving parity in insurance coverage for alcohol, drug and mental health treatment is imperative.

Implementation of insurance parity and managed care reform should include:

- Meaningful equity with medical and surgical benefits in the provision of alcohol/drug and mental health benefits for both in- and out-of-network benefits;

- Parity for benefits for treatment of the full range of substance use disorders and mental health conditions in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition (DSM-IV);

- The provision of medical necessity criteria and reasons for any denials of reimbursement to participants and beneficiaries upon request;

- The protection that state laws which provide better insurance and consumer protections remain in effect and are not preempted by new federal laws or policies; and

- The requirement that managed care companies make fair and medically appropriate decisions in terms of approving the types and duration of treatment covered.

Almost a decade ago, under the Clinton Administration, insurance parity was authorized for the Federal Employees Health Benefits Program (FEHBP), which required 285 participating insurance companies to offer full drug and alcohol addiction and mental health parity. The FEHBP is the largest private insurer and this change affected over 9 million individuals. The FEHBP's implementation of parity should be evaluated in terms of how it has affected the provision of drug and alcohol treatment services under the program so that lessons can be learned to strengthen any future parity or managed care reform implemented at the federal or state level.

Broad insurance reform and public health care program restructuring is a large and long-term task that is urgently needed. However, drug and alcohol addiction could be addressed immediately in order to save both lives as well as billions of dollars in health, welfare, criminal justice and social costs.

If the U.S. took only the first step of providing treatment and recovery services to an additional 1 million Americans annually – 5 percent of those who are underserved – and phased in service expansion over 5 years, it would cost approximately $4 billion per year. While this is a significant amount of money, helping another 1 million Americans achieve and maintain recovery would save countless lives and both public and private sector funding. Next to these enormous actual and social costs, $4 billion is a small price to pay to provide treatment and recovery services to an additional 1 million Americans per year.

2. **Ensure that this expansion of capacity can be achieved and maintained, and that services will be high quality, by implementing initiatives to enable the treatment and recovery field to recruit and retain a qualified workforce. Such initiatives would include the creation of a loan forgiveness program for addiction professionals.**

Expanding access and improving the effectiveness of alcohol and drug treatment and recovery services will require the expansion and increased training of the addiction field's workforce. Better recruitment and retention of the addiction treatment workforce is key to the long-term improvement of treatment quality. Presently, there are a number of workforce challenges confronting the alcohol and drug addiction prevention and treatment fields, including a shortage of workers, the aging of the current workforce, inadequate counselor salaries, the need to have a diverse, culturally competent workforce as well as the continuing stigma associated with addiction.

The impending workforce crisis was recently documented in the 2006 Institute of Medicine (IOM) Report, "Improving the Quality of Health Care for Mental and Substance-Use Conditions." Currently, more than 67,000 practitioners provide addiction treatment; the average age of clinical staff is in the mid 40s to 50s and 75 percent of the workforce is over the age of 40. It has been estimated that 5,000 new counselors are needed annually for net staff replacement and growth. In addition to these challenges of

recruiting and retaining qualified counselors is the growing body of scientific research related to evidence-based practice – techniques that have been proven effective at preventing and treating addiction – that must be transferred and implemented in the field. These include not only cognitive-behavioral interventions and the utilization of medications in treatment but also the movement toward a recovery-oriented system of care.

To support and expand the appropriate staffing of the addiction treatment and prevention field, there must be an infusion of funding to support more workforce recruitment and retention initiatives, including:

- Development and implementation of an assertive marketing strategy to attract workers to the addiction profession.

- Increased investment in training and technical assistance for programs to ensure that addiction professionals are utilizing up-to-date, evidence-based practices.

- Development and infusion of national addiction core competencies and accreditation standards into academic curricula across medical, social and criminal justice disciplines. The fact that many health care providers get fewer than three hours of addiction training or course work in school exemplifies the need for this change.

- Support for policies that enable persons in recovery to obtain the skills and meet the requirements necessary to become addiction treatment counselors and program administrators.

- Creation of a loan forgiveness program for addiction professionals and an increased pay scale that better compensates workers in such a challenging field.

3. **Make treatment available for all non-violent, addicted persons charged with or convicted for low level offenses who would be more effectively addressed by drug and alcohol treatment rather than prison.**

There is a clear link between crime and the use of alcohol and other drugs. Research has shown that between 60 and 80 percent of individuals under supervision of the criminal justice system were under the influence of alcohol or other drugs during the commission of their offense, committed the offense to support a drug addiction, were charged with a drug-related crime, or are regular substance users. In addition, most of the individuals under the supervision of the criminal justice system with alcohol and drug problems and addictions have never received treatment in the community other than detoxification. Since detoxification is the first of several stages within the continuum of addiction treatment, without further care it has minimal impact on an individual’s ability to stop using drugs over the long-term.

Individuals under the supervision of the criminal justice system who are addicted, whether incarcerated or released into the community, need access to comprehensive treatment services that will help them break free of the cycle of drugs and crime. Increasing such access would include:

- Screening of arrested adults and juveniles for drug and alcohol problems, and referring those assessed as needing treatment and who are eligible for diversion or pretrial release to appropriate community-based treatment and aftercare.

- Expanding access to court-supervision programs, such as drug courts, that supervise addicted individuals who are arrested or convicted and provide access to appropriate treatment and support services.

- Expanding treatment, aftercare, and support services for individuals who are incarcerated and returning to the community. Currently, a very small percentage of incarcerated individuals are served by the Residential Substance Abuse Treatment program, which provides drug addiction treatment services in State and local correctional facilities, in addition to aftercare services for individuals released back into the community.

4. **Assure quality of treatment and recovery support services by funding practices that have been proven effective, including appropriate medications and access to the full continuum of care; providing technical assistance and training to implement evidence-based practices; and enabling treatment providers to use the latest in information technology, such as video consultation and electronic health records, to improve patient health and safety.**

The development of new science has been a critical factor in helping to improve the effectiveness of drug and alcohol treatment. Funding new and proven treatment techniques, including emerging medications, will facilitate putting the best practice into place. Without additional treatment funding, however, providers are often unable to put the most cutting-edge services into place – new medications are more expensive and new treatment techniques often require additional funding that was never previously budgeted.

Providing access to the full continuum of treatment and care is also essential to promoting effectiveness – patients are not able to easily go from one level of care to the next because access to treatment is so limited. This problem can delay entrance into the next appropriate level of care for a patient, causing unnecessary expenditures at more expensive programs while a patient waits for a treatment slot to open at a more appropriate level of care. For example, some third party payors fund detoxification but do not fund follow up treatment and care. This is clinically inappropriate and sets up the patient to fail – detoxification is only the first step in the treatment of addiction, and follow up services are necessary to help make long-term recovery a reality.

Additionally, once the science is discovered and evaluated, there is a need to transfer this information to treatment and prevention providers through training and technical assistance in order to improve front line practice. Maintaining ties and improving training for the essential recovering community who has long served as front-line staff for many community-based drug and alcohol treatment programs also is essential to effectively engage and retain clients in treatment and provide critical aftercare and relapse prevention. Recovery support services provide essential support and skills that increase treatment effectiveness as well as the likelihood of long-term recovery.

Finally, facilitating access to the latest information technology, including video consultation and electronic records, will improve effectiveness and expand access to care, especially for populations located in rural regions, and improve patient health and safety by providing accessible and more complete information.

B. **Expand prevention initiatives that have proven successful for young people, families, communities, and schools. By investing slightly less than $1 billion per year over a 5 year period, the U.S. could support a comprehensive prevention strategy targeting the most at-risk populations.**

Research over the last two decades has proven that not only is drug and alcohol addiction treatable, it is also preventable. For many adults who experience drug and alcohol use disorders in adulthood, their use began in adolescence, sometimes as early as childhood. According to studies by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute on Drug Abuse (NIDA), the younger a person first uses drugs or alcohol, the higher their chance of adult drug and alcohol dependency and addiction. For example, youth who first smoke marijuana under the age of 14 are more than five times as likely to abuse drugs in adulthood.[iii] According to a longitudinal study of students in three States, middle school students were almost three times more likely to use alcohol if they had previously used alcohol in elementary school.[iv] Similarly, of youth who began drinking before age 15, 40 percent were classified as dependent later in life whereas of youth who began drinking between the ages of 17 and 21, 24.5 percent were classified as dependent, and of youth who began drinking at age 21 or 22, 10 percent were classified as dependent.[v]

Youth who drink or use drugs are also at risk for many other harmful behaviors including increased risky sexual activity, violence and school problems or school drop out. According to a national survey of sexually active young people, 12 percent of teens aged 15 to 17 reported having unprotected sex as a result of drinking or using drugs. In addition, 24 percent reported that because of their substance use, they had "done more" sexually than they had planned.[vi]

Youth drug and alcohol use is not just “kids being kids.” Youth drug use is not harmless and youth alcohol consumption is not a rite of passage to adulthood. Most importantly, drug and alcohol use by adolescents can be prevented. Youth substance use prevention must be a critical component for any national strategy to reduce or treat drug and alcohol use.

There are four major targets of prevention: youth, parents, schools (including colleges and universities) and communities/environments. Research has clearly identified that each of these domains needs to be reinforced by the others to have the greatest affect in deterring the consequences of underage alcohol use and illicit drug use. Consequently, no single entity bears the sole responsibility for preventing drug and alcohol use and abuse: not parents, the child, the school, nor the community. Rather a comprehensive blend of individually and environmentally focused efforts must be adopted and multiple strategies must be implemented across multiple sectors of a community to reduce drug and alcohol use.

In order to effectively implement a comprehensive prevention effort that addresses each of the identified domains, targeted and strategic financing of identified individual and environmental prevention efforts must be accomplished. Historically, substance use prevention has been severely under funded at the federal and state levels, relative to its importance and effectiveness in reducing drug and alcohol use. In fact, a recent report by Columbia University’s National Center on Addiction and Substance Abuse (CASA) found that only about one half cent of every dollar that states spend on substance use goes for prevention.[vii] Investments in prevention can pay huge dividends. The savings per dollar spent on alcohol and drug prevention are substantial and range from $2.00 to $19.64, depending on the methodology used to calculate costs and outcomes.[viii]

To implement a comprehensive prevention strategy, the U.S. should:

1. **Create 1,187 new coalitions that identify and respond to local substance use problems so that every community in the country has one.**

Coalitions that address drug use and underage drinking are a necessary component of the community-based infrastructure for prevention. Coalitions are local partnerships between multiple sectors of a community that work collaboratively to develop and implement a data-driven, comprehensive, community-wide strategy for preventing drug and alcohol use and abuse. Coalitions implement a diverse set of environmental strategies to create an environment that discourages the use and abuse of drugs and alcohol. Originally funded by Congress in 1997 with the understanding that local problems need local solutions, the Drug-Free Communities (DFC) program now supports over 700 drug-free community coalitions across the United States. As a cornerstone of ONDCP's National Drug Control Strategy, DFC provides the funding necessary for communities to identify and respond to local substance use problems.

Research shows that the maximum number of people who can be effectively served by one coalition is 125,000.[ix] The number of community coalitions required to ensure that everyone in the country is served by a coalition is 2,418. Since the programs inception, 1,231 current and past Drug Free Communities (DFC) [x] grantees have been funded. Therefore, the total number of additional coalitions that need to be funded to ensure that there is full national coverage for DFC coalition infrastructure is 1,187.[xi] The total amount of funds needed to sustain these coalitions is $148,375,000 per year for five years, or a total $741,875,000.[xii]

2. **Double school-based programming targeting youth, parents and educators, including prevention for an addition 6.6 million middle and high school students**.

The average cost for implementing evidence based universal programming for alcohol and drugs at the years of highest risk, with a booster before college is approximately $743.2 million per year or twice the total current allocation of $346.5 million for the Safe and Drug Free Schools and Communities (SDFSC) grant.[xiii] Expanding school-based programming targeting youth, parents and educators to prevent and reduce underage drinking and illicit substance use would require $396.5 million per year for the SDFSC program.

3. **Create universal access to prevention services for high risk youth by annually expanding student assistance services by an additional 1.2 million youth over five years.**

There are approximately 6 million high risk youth in grades 6-12, who represent 20 percent of the 30 million students enrolled in secondary schools in the nation in 2005 (the latest year for which data is available.) Youth in juvenile detention facilities, residential facilities for troubled youth, and young people who have dropped out are not included in this number. The average cost of prevention services targeted to high risk youth is $203 per student per year. To provide student assistance services for 20 percent of the high-risk student population each year for five years requires an investment of $254 million a year.[xiv]

4. **Expand higher education prevention and education programs targeting high-risk behavior of college students.**

According to the U.S. Department of Education, there are an estimated 17.5 million people enrolled in higher education, degree-granting institutions. A recent study found that 49 percent (3.8 million) of full

time college students binge drink and/or abuse prescription and illegal drugs. The study, *Wasting the Best and the Brightest: Substance Abuse at America's Colleges and Universities*[xv], also found that 1.8 million full-time college students (22.9 percent) meet the medical criteria for substance abuse and dependence, two and one half times the number of the general population who meet these same criteria.[xvi]

By investing $150 million a year for five years, a total investment of $750 million, college and university prevention and education efforts would be able to more effectively target the high-risk behaviors of college students.

C. **Increase funding for the National Institute on Drug Abuse by $500 million and the National Institute on Alcohol Abuse and Alcoholism by $220 million to continue and expand ground-breaking research**.

Scientific research led to the discovery that addiction is a chronic disease of the brain. As researchers continue to learn about alcoholism and drug addiction, these findings will continue to refute powerful myths and misconceptions about the nature of addiction and will inform policy-makers about the preventative and therapeutic actions that can be taken to combat it. Continuing to support groundbreaking research will provide a more effective response to the problem of addiction

Over the past several years, the National Institute on Drug Abuse (NIDA) has made extraordinary scientific advances in understanding the nature of addiction, such as those made through the use of imaging technologies such as positron emission tomography (PET scans), and through the development of new treatment technologies and medications, such as buprenorphine used to treat opiate addiction. Research on addiction as a disease also has been essential in the development and testing of new science-based therapies.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) also has conducted breakthrough research that has improved clinical practice, with much of this research focusing on the genetics, neurobiology, and environmental factors that underlie alcohol addiction. NIAAA also has sought to use new information about alcohol use to promote education and an effective public health response to this problem.

Federal resources for scientific research on alcohol and drug addiction must be increased by 50% over five years in order to continue the scientific progress achieved on this issue. Increasing the support available for research on drug and alcohol addiction would permit future research to focus on some of the most pressing questions about addiction and the provision of treatment and prevention services, including:

- Medications development.
- Gene-environment interactions in the etiology of substance use and addiction.
- Treatment and service delivery throughout the criminal justice system.
- Adolescent vulnerability and decision-making and resulting prevention strategies.
- Recovery and its nature, characteristics, and demographics.

II. ELIMINATE DISCRIMINATION AGAINST PEOPLE IN RECOVERY

In 2001, a poll conducted for Faces and Voices of Recovery by Peter Hart & Associates found that 24% of people in recovery report suffering discrimination in employment, insurance, or both.[xvii] Such discrimination reflects the myths that society continues to believe about addiction – that it is not a preventable and treatable disease from which there can be a productive and successful recovery, but instead a lack of will or desire by the addicted person to abstain from alcohol and drugs.

Society perpetuates this stigma when it promulgates laws and policies that discriminate against individuals with a history of alcohol or drug addiction, or a related criminal record. Ridding society of these unfair policies would help support those individuals who need access to treatment and who are living in recovery by both reducing the stigma of addiction and by creating access to a wide variety of legal protections and public programs that contribute substantially to a person's ability to gain and maintain recovery.

A. Eliminate discrimination based on alcohol/drug history:

1. **Require parity in insurance coverage and reform managed care practices so that everyone who is addicted can obtain the level and duration of care they need.** (For more details, please see Part I, Section A, Subpart 2.)

2. **Protect individuals in early recovery and those willing to enter treatment from employment discrimination.**

The American with Disabilities Act, the Rehabilitation Act, the Fair Housing Act, and other laws protect qualified individuals with current, past or perceived disabilities against discrimination. Individuals with current alcohol problems, and those with past or perceived alcohol or illegal drug use problems, are protected against discrimination under each law. Individuals currently using illegal drugs are not protected against discrimination under these laws, although they may not be excluded from or denied health services or other services provided in connection with drug rehabilitation if they are otherwise entitled to such services. It is important to make sure that these legal protections also cover individuals in early recovery and those who are willing to enter treatment – such protections would help to prevent employment discrimination as well as other forms of discrimination and encourage individuals to come forward for the treatment they need.

These protections are critical, because they prevent employers from discriminating against employees with addiction problems who are able to go into treatment and recovery and continue their employment. Employers also may not deny potential employment based on inappropriate interview questions about past addiction and treatment – the same rule that would apply for other disabilities.

It is critical to enforce these disability rights laws so that individuals will not be afraid to go into alcohol and drug treatment and recovery when they are employed or seek new employment once they are in recovery. As stated at the beginning of this paper, over 77 percent of the persons classified with alcohol and drug problems in America are employed, and enabling their ability to seek treatment and maintain the ability to work is key to significantly reducing the impact and costs of addiction on individuals, families and society.

3. **Restore eligibility for Social Security disability benefits for individuals with a primary diagnosis of addiction.**

Supplemental Security Income (SSI) is a federal means-tested assistance program for poor blind, disabled, and aged persons and Social Security Disability Insurance (SSDI) is a program for disabled people eligible to receive Social Security benefits. In 1996, Congress eliminated SSDI and SSI benefits for persons whose primary disability was alcoholism or drug addiction. This policy change was an attempt to prevent addicted individuals from spending benefits money on alcohol or drugs. The Social Security Administration estimates that when the law went into effect, more than 123,000 individuals lost their SSI/SSDI benefits.

This federal policy discriminates against individuals who are legitimately disabled by their addiction and who could use SSI/SSDI benefits to help gain access to treatment and recovery services, as well as support. Safeguards could be implemented into the SSI/SSDI program to prevent the inappropriate expenditure of benefits on alcohol and drugs – such as mandating participation in treatment as a condition of receiving benefits and designating a third-party payee that is a relative or drug treatment or recovery program. The payee would receive the monthly benefits and ensure their responsible distribution for individuals whose qualifying disability is addiction. In fact, such reforms were enacted briefly before Congress removed SSI/SSDI eligibility for addiction. Unfortunately, there was no opportunity to evaluate and confirm the effectiveness of such safeguards.

Restoring eligibility for the SSI/SSDI programs for individuals who are disabled by addiction would reduce discrimination and increase access to treatment and recovery.

B. **Eliminate discrimination based on criminal history**:

1. **Enact the Second Chance Act to begin a review of discriminatory barriers and assist the re-entry into society of people with criminal records.**

Re-entry affects millions of people: In 2002, 2 million people were incarcerated in Federal or State prisons or in local jails.[xviii] Nearly 650,000 people are released from state and federal prison, and many more from county jails, back into communities nationwide each year[xix]

There is a clear link between crime and the use of alcohol and other drugs. Research has shown that between 60 and 80 percent of individuals under supervision of the criminal justice system were under the influence of alcohol or other drugs during the commission of their offense, committed the offense to support a drug addiction, were charged with a drug-related crime, or are regular substance users. In addition, most of the individuals under the supervision of the criminal justice system with alcohol and drug problems and addictions have never received treatment in the community other than detoxification. Since detoxification is the first of several stages within the continuum of addiction treatment without further care it has minimal impact on an individual's ability to quit using drugs. Access to comprehensive alcohol and drug treatment and recovery support services is essential to help individuals involved in the criminal justice system to break the cycle of drugs and crime and successfully re-enter the community.

Additionally, criminal records create barriers to re-entry: over 59 million Americans - and probably many more – have a criminal history on file with state or federal governments. This means that about 27 percent – or more than 1 out of 4 – of the nation's adults have a criminal record, thus making it more difficult for them to gain employment, housing and access to public benefits.[xx]

A strong re-entry/transition process – through which inmates are prepared for release, leave prison, return to communities, and adjust to free living – is needed to enhance public safety.[xxi] 97% of the individuals now in prison eventually will be released and will return to communities,[xxii] often without assistance or services. Many men and women leave prison and jail with substance use disorders, chronic health issues, low levels of education and job training, and a lack of resources to help them truly reintegrate.[xxiii] Research confirms that these services – education, job training, job placement, job retention, and alcohol and drug treatment – are essential to help formerly incarcerated individuals obtain work, housing, and avoid recidivism.

When formerly incarcerated individuals are not provided re-entry services, they often re-offend, and recidivism rates cause considerable direct and indirect costs that nationally amount to billions of dollars. Effective reintegration programs reduce recidivism and therefore reduce the cost of re-incarceration. A report based on the Philadelphia Prison System found that if it could reduce recidivism rates by just 10% it would save $6.8 million a year in jail costs alone.[xxiv]

Successful re-integration of formerly incarcerated individuals also benefits the community and individual in ways that cannot be measured in dollars. The social value of re-integration is measured by a formerly incarcerated person's ability to contribute to the support of his or her family, provide a healthy environment for his or her children and enhance the positive human resources in the community. To accomplish these ends, we must examine and implement effective interventions that will help individuals with criminal records find the path to productive community involvement.

Enacting the "Second Chance Act," re-entry legislation that was passed by the House of Representatives this past year, would begin a review of discriminatory barriers and assist the reentry into society of people with criminal records. The legislation would provide support to State and local jurisdictions to create or improve re-entry services needed to help individuals returning from incarceration maintain housing, gain employment, and receive necessary health and other social services.

2. **Repeal unfair federal- and state-based barriers to obtaining food stamps, public benefits, student loans, employment, housing, and voting rights.**

Over the last two decades, several public benefits programs and some laws have adopted discriminatory policies that reduce or eliminate access to support for individuals with criminal records, especially records for crimes involving alcohol or drugs. Repealing this discriminatory laws and policies would increase access to these important programs and protections, and help individuals with criminal records better re-integrate into society and help those with addiction histories attain and maintain recovery and lead law-abiding and productive lives.

Some of the key barriers that should be removed include:

- ***Eliminating the ban on Temporary Assistance for Needy Families (TANF/welfare) and food stamp benefits for individuals with drug felony convictions.***

Section 115 of the 1996 welfare law, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), prohibits anyone convicted of a drug-related felony from receiving both federally-funded cash assistance through the TANF program and food stamps unless States opt out of or modify the ban. Currently, sixteen States completely deny benefits on the basis of this ban and eleven States partially deny benefits. Almost 100,000 women and nearly 150,000 children in the States that are enforcing the ban have been affected due to ineligibility for cash assistance or food stamps.

Under the ban, individuals are barred for life from obtaining cash assistance and food stamps even after completing their sentence, and overcoming an addiction. Individuals with criminal convictions face considerable barriers to employment, often needing transitional services and support to improve their ability to acquire gainful employment. The ban is an additional barrier to addressing addiction and to reintegrating individuals with criminal histories into the community because it makes it more difficult for them to obtain treatment, food and to secure employment.

An increasing number of women, particularly low-income women and women of color, are being incarcerated, and a policy that denies individuals cash assistance and food stamps based solely on a criminal conviction disproportionately affects these women. Currently, there are over 200,000 women incarcerated in prisons and jails in the United States. Forty-eight percent of those women affected by the TANF drug felony ban are African-American and Latina. Nearly 35,000 African-American women and almost 10,000 Latinas are affected by the ban. When a mother is denied cash assistance or food stamps her children suffer. A family's funds go toward caring for the entire family, not just the individuals who qualify for federal assistance. Food stamps and cash support are essential to the health and stability of families. The felony drug ban significantly impedes the ability of an individual to transition back into the community, reintegrate into the family, and access and maintain sustainable employment.

- ***Fully repealing the student financial aid ban for individuals with drug convictions.***

In 1998, Congress reauthorized the Higher Education Act (HEA), which funds educational financial aid for students. During consideration of the HEA, Congress approved an amendment to the legislation that delayed or denied federal financial aid for students convicted of a drug offense. Students applying for federal financial aid are asked on the FAFSA (Free Application for Federal Student Aid) form whether they have ever been convicted of "possessing or selling illegal drugs." If an applicant answers anything other than "no," the applicant is required to fill out a worksheet to determine if and when the applicant will resume eligibility for federal student financial aid. It is estimated that over 128,000 students applying for federal financial aid have been denied assistance because of this provision.

In February of 2006, legislation was approved by both chambers of Congress and signed into law by the President that partially repeals this student aid provision. Public Law 109-171 partially repeals the ban on student federal financial aid for persons convicted of drug crimes so that only students who are convicted of a drug offense while they are in school and receiving federal financial assistance will be affected by the ban.

Although the law provides that a student can resume eligibility for aid if that student satisfactorily completes a drug rehabilitation program, the reality is that accessing treatment services can be extremely difficult and treatment delays can prevent students who lose financial aid eligibility from returning to school. The federal Substance Abuse and Mental Health Services Administration and the Institute of Medicine have estimated that only 10 percent of the individuals who need drug and alcohol treatment in any given year receive care, and waiting lists in some jurisdictions are more than six months long.

By cutting off necessary financial assistance, this provision decreases the number of people completing college, thus diminishing their employment prospects and potential contributions to the economy. And for other individuals who are eligible for aid since their conviction is from a time previous to school, the question about drug convictions remains on the FAFSA form and potentially discourages thousands of these individuals from applying for financial aid because of the uncertainty about their eligibility.

Access to education is essential if individuals are to participate successfully in society and the economy. The ban on financial aid for individuals with certain drug convictions should be completely repealed to remove these barriers.

- ***Removing barriers to employment for individuals with criminal records.***

More and more employers are conducting criminal background checks on job applicants, which can make it much more difficult for the millions of Americans with criminal records to find employment and become productive, law-abiding members of society. Most states allow employers to refuse to hire people with criminal records; not only individuals who have been convicted – even if they have paid their debt to society and demonstrated their ability to work without risk to the public – but also those who were arrested and never convicted. Although no one questions the legitimate concerns of employers who do not want to hire someone with a conviction record who clearly demonstrates a threat to public safety or who otherwise has a conviction history directly related to a specific job, policies that encourage employers to adopt broad sweeping exclusions (i.e. not hiring or considering anyone with any type of criminal history) simply locks out and eliminates many qualified, rehabilitated individuals from the job market.

States should have laws that prohibit across-the-board employment discrimination against people with criminal records and instead require employers to make individualized hiring decisions by applying specific standards. The law should incorporate standards that will guide employers to make fair and appropriate employment decisions that will effectively address the needs of qualified individuals with criminal records seeking a fair chance as well as address legitimate employer and public safety concerns.

Additionally, employers should not be able to deny employment based on an arrest that did not lead to a conviction, and those who are denied employment may be able to challenge the decision under Title VII of the Civil Rights Act of 1964 and, if one exists, similar state laws. Title VII can be used to challenge denials of employment (or other opportunities) based on arrests that never resulted in conviction, or convictions unrelated to the nature of employment.

- ***Removing unfair legal, policy and practical barriers to housing.***

Individuals with criminal records face many challenges upon re-integrating back into society, but frequently their most immediate need is securing safe and affordable housing. While the lack of affordable housing is often a problem for individuals who lack financial resources, this problem is compounded for persons with conviction records. They often find that a conviction record is the main stumbling block in obtaining housing, whether in the private sector or in public and Section 8 supported housing.

Many of the policies that housing authorities or private landlords use to exclude people with conviction records are overly restrictive, effectively denying housing to people who pose no threat to the public, tenants or property. Oftentimes the policies are based on a misunderstanding of federal law, or on the landlord placing a premium on ease of administration, believing that it's easier to "just say no" to all people with conviction records than to perform individualized analyses of their applications. These polices should be changed to increase access to urgently needed housing.

Public housing authorities and private landlords should adopt policies that, rather than barring any applicants who have criminal records, instead individually assess each applicant based on the:

- Seriousness and nature of his or her conviction
- Relevance of that conviction to the tenancy
- Length of time that has passed since the conviction, and
- Evidence of rehabilitation.

Additionally, neither public agencies nor private landlords should base a decision on an arrest that never led to conviction.

States also should create Certificates of Rehabilitation that public agencies and private landlords must consider when evaluating the application of an individual with a criminal record. Such a document would help to create a level of certainty for landlords and would reduce the burden on individuals who must collect such documentation in an ad hoc nature.

Implementing such policies would help to significantly increase access to housing – the cornerstone to successful participation in society.

- ***Promoting civic participation and rehabilitation by providing full and fair voting rights to individuals who are no longer incarcerated.***

Felony disenfranchisement laws, which vary from state to state, currently disqualify almost 4 million American adults from voting. As a result of these laws, 13 percent of African American males are prohibited from voting, and 75 percent of the disqualified voters are not in prison, but are on probation, parole or have criminal records. The removal of voting privileges often is imposed regardless of the nature or seriousness of the offense, and in some states the loss of voting privileges is permanent. The result is a discriminatory removal of the right to vote for individuals who should be able to fully participate in society.

Passage of federal legislation could permit individuals who are no longer incarcerated to vote in federal elections. Such a policy change would serve as a model for states that wish to enact similar statutes for state and local elections, as well as an incentive for individuals affected by the criminal justice system to fully re-integrate back into society.

3. **Eliminate mandatory incarceration and mandatory minimum sentences for drug crimes in order to give courts flexibility in sentencing addicted individuals to alcohol and drug treatment and other successful alternatives to incarceration that break the cycle of addiction and crime; this would include eliminating the disparity in sentencing for crack and powder cocaine, which also deters access to treatment through alternatives to incarceration and punishes African-Americans and Latinos more severely for similar illegal acts.**

As stated earlier in this paper, there is a clear link between crime and the use of alcohol and drugs, and persons who are actively addicted are not deterred from possessing or selling drugs by extremely harsh prison sentences. Drug and alcohol treatment services repeatedly have been shown to effectively reduce crime and drug use and help ensure the individual's successful reentry into society. Many jurisdictions nationwide have implemented alternative to incarceration programs, such as drug courts, to better address

the issue of drugs and crime. Eliminating mandatory incarceration and mandatory minimum sentences for drug crimes would give courts flexibility in sentencing addicted individuals to drug treatment and/or successful alternative to incarceration programs.

Additionally, alternatives to incarceration that utilize mandated addiction treatment, where appropriate, would save taxpayer dollars as the cost of addictions treatment is 15 times less than the cost of incarcerating a person for a drug-related crime and would reduce recidivism. Additionally, numerous studies have demonstrated that treatment is as effective when the individual is required to participate as a condition of deferred prosecution, sentence, or other criminal justice disposition as when the individual enters treatment voluntarily. Research also has shown that combining criminal justice sanctions with drug treatment is effective in decreasing drug use and related crime, and that treatment retention rates for individuals under legal coercion are higher than for others not under legal pressure.

One particularly unfair federal mandatory sentencing policy that should be permanently changed in favor of court discretion is the sentencing disparity for crack and powder cocaine. The science has demonstrated that both drugs derive from the same substance, therefore there is no scientific basis for the differing sentences for these offenses. Eliminating these sentencing differences for individuals convicted of crack and powder cocaine offenses would both reduce the disparity in punishment for African-Americans and Latinos (who are disproportionately affected by such harsh sentencing laws) and help expand alternatives to incarceration and treatment for individuals who are addicted to these drugs.

The Supreme Court's December 2007 ruling on this issue provides judges with the guidance that they may use their own discretion in sentencing on these issues. However, while this decision, coupled with the U.S. Sentencing Commission's earlier decision to reduce the sentencing ranges for crack cocaine offenses, both represent major steps forward, laws and guidelines officially perpetuating such sentencing disparities should be changed and resolved so that there is fairness and clarity in U.S. sentencing policy.

Endnotes

[i] Hubbard, R.L. (1997). Overview of 1-year Follow-up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS). Psychology of Addictive Behaviors, 11, 261-278. (2003) Overview of 5-year Follow-up Outcomes in the Drug Abuse Treatment Outcomes Studies (DATOS). 263-70.

[ii] Principles of Drug Addiction Treatment: A Research Based Guide, National Institute on Drug Abuse, http://www.nida.nih.gov/PODAT/PODAT6.html#FAQ11

[iii] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Science. (2003). *The 2002 National Household Survey on Drug Use.* Rockville, MD.

[iv] Wilson N, Battistich V, Syme L, et al. Does elementary alcohol, tobacco, and marijuana use increase middle school risk? *J Adolesc Health* 30(6):442 447, 2002. Downloaded from http://ncadi.samhsa.gov/govpubs/prevalert/v6/2.aspx, accessed on June 25, 2007.

[v] Grant, B.F.**,** and Dawson, D.A. Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. *J Sub Abuse* 9:103-110, 1997.

[vi] Kaiser Family Foundation. *Survey Snapshot: Substance Use and Risky Sexual Behavior: Attitudes and Practices Among Adolescents and Young Adults*. Menlo Park CA: The Henry J. Kaiser Foundation, 2002. Downloaded from http://ncadi.samhsa.gov/govpubs/prevalert/v6/2.aspx. Accessed on June 25, 2007.

[vii] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2001). *Shoveling up: The impact of substance abuse on state budgets*. Columbia, SC. 2, 17. Available: http://www.casacolumbia.org/pdshopprov/files/47299a.pdf.
[viii] Swisher, John. (2004). *Journal of Primary Prevention.* "Cost-benefit estimates in prevention research." (25)12.
[ix] Lindholm, M. (2001). *RWJ and the Grassroots: Race and Administration in the Social Construction of Inner City Communities.* Doctoral Dissertation. City University of New York. New York.
[x] The concept behind the Drug-Free Communities (DFC) program is that communities around the country must be organized and equipped to deal with their individual substance abuse problems in a comprehensive and coordinated manner. The program explicitly recognizes that federal anti-drug resources must be invested at the community level with those who have the most power to reduce the demand for drugs - parents, teachers, business leaders, the media, the faith community, law enforcement officials, youth, and others. This program is unique in that federal support is contingent upon a community demonstrating local commitment, resolve and a dollar-for-dollar match to address its drug problem, before it is eligible to receive any federal funds. Communities funded under the DFC program receive grants for a five-year period.
[xi] This number derived by subtracting the total number of current and past DFC grantees from the optimal number of community anti-drug coalitions.
[xii] This number is derived by multiplying the total number of additional coalitions needed to reach the optimal number of coalitions by the current yearly grant award total of $125,000 and multiplied by five years (the duration of the grant award).
[xiii] There are approximately 4.3 million 7th graders; 4.7 million 9th graders and 3.4 million 12th graders currently enrolled. At a minimum these students should receive 10 "units" of prevention in grade 7, 7 "units" in grade 9 and 5 "units" in grade 12. A typical "unit" of prevention programming costs $8 per student per hour.
[xiv] The cost range for a full time Student Assistance Counselor (SAC) who provides resources for high-risk youth ranges from a low of $22,000 in rural areas of upstate NY to $55,000 in the NY metro area for an average of $38,000. If you assume that approximately 80 percent of a SAC's time is spent on direct services to these populations and that 150 students receive targeted services for an average of seven sessions (which may include sessions with their parents), then the average cost per session would be $29. (80percent of $38,000=$30,400 divided by 150 students per year =$203 per student divided by seven sessions = $29 per session/visit.)
[xv] "Wasting the Best and the Brightest," CASA press release, March 15, 2007; online at http://www.casacolumbia.org/absolutenm/templates/PressReleases.aspx?articleid=477&zoneid=65
[xvi] In the general population, 8.5 percent meet the criteria for a substance use dependence diagnosis. "Wasting the Best and the Brightest," CASA press release, March 15, 2007; online at http://www.casacolumbia.org/absolutenm/templates/PressReleases.aspx?articleid=477&zoneid=65
[xvii] "The Face of Recovery," Peter D. Hart Research Associates, October 2001
[xviii] BJS, http://www.ojp.usdoj.gov/bjs/prisons.htm
[xix] Office of Justice Programs (OJP) website, www.ojp.usdoj.gov/reentry/learn.html
[xx] "Use and Management of Criminal History Record Information: A Comprehensive Report, 2001 Update," http://www.ojp.usdoj.gov/bjs/pub/ascii/umchri01.txt
[xxi] National Institute of Corrections, http://www.nicic.org/resources/topics/TransitionFromPrison.aspx
[xxii] Id.
[xxiii] Philadelphia Consensus Group on Reentry and Reintegration of Adjudicated Offenders, "They're Coming Back: An Action Plan for Successful Reintegration of Offenders that Works for Everyone." Hard copy available upon request.
[xxiv] See supra note vii.