



Board of Directors

Daniel K. Mayers
Chairman
Elizabeth Bartholet
Vice Chair
Eric D. Balber
Derrick Cephas
Suzanne B. Cusack
Stephen M. Cutler
Edward J. Davis
Jason Flom
Mary Beth Forshaw
Diana R. Gordon
Brad S. Karp
Richard C. Lee
Doug Liman
Elaine H. Mandelbaum
Michael Meltsner
Mark C. Morrill
Mary E. Mulligan
William C. Paley
Dallas Pell
Sandra Ruiz Butter
Ed Shaw
Jane Velez

Trustee Emeritus

Allan Rosenfield, MD

Founding Chairman

Arthur L. Liman
From 1972 to 1997

Executive Staff

Paul N. Samuels
Director and President
Catherine H. O'Neill
Senior Vice President
Anita R. Marton
Vice President
Martha R. Acero
Vice President/CFO
Sally Friedman
Legal Director

Health Policy Reform: A Roadmap for Smarter and More Effective National and State Alcohol and Drug Policies

CONTENTS

I. The Case for Drug and Alcohol Policy Reform

II. Five Key Principles to Drug and Alcohol Addiction Policy Reform

III. Policy Reform Recommendations

- A. Expand and improve health responses to addiction
 - 1. Ensure equitable and adequate alcohol and drug treatment and recovery support as an integral part of health care
 - 2. Expand prevention initiatives that have proven successful for young people, families, communities, and schools.
 - 3. Significantly increase funding for research
- B. Eliminate discrimination against people in recovery
 - 1. Eliminate discrimination based on alcohol/drug history
 - 2. Eliminate discrimination based on criminal history

IV. Conclusion

Endnotes

THE CASE FOR DRUG AND ALCOHOL POLICY REFORM

The economy, health care, and crime. Polls consistently show that these issues are among American voters' top concerns. Adequate attention to one single social factor could have a positive and exponential impact in responding to all of these concerns. That factor is untreated and preventable drug and alcohol addiction.

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. Individuals in recovery often suffer discrimination as they seek employment, insurance, and other necessities of life. This failure to integrate addiction prevention, treatment and recovery effectively into our nation's health care structure *costs 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:

*** Expand and Improve Health Responses to Addiction: 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 Americans.**

*** Eliminate Discrimination Against People in Recovery: Repeal Discriminatory Laws and Policies.**

Harmful use of alcohol and drugs undermines the functioning of American society. Not only does it take a devastating personal, social, and financial toll on individuals, families, and entire communities, but it hinders progress in the public policy issues of top concern to American citizens.

Impact of Untreated Addiction on the Economy, Health Care, and Crime

Untreated alcohol and drug addiction drains the U.S. economy of at least \$346 billion per year.ⁱ Seventy-five percent of people with alcohol and drug problems are employed, and their problems cost employers more than \$144 billion annually.ⁱⁱ Alcoholism alone is responsible for 500 million lost work days each year.ⁱⁱⁱ Individuals with untreated drug and alcohol problems, employed or not, compound their costs to society when they become chronic consumers of criminal justice, public health, and social welfare resources.

Untreated addiction places an enormous burden on the nation's health care system. Nearly 1.3 million emergency department visits in 2004 were related to harmful drug use, and that figure does not include uncounted visits related to alcohol alone.^{iv} Approximately 120,000 deaths each year are due to harmful drug and alcohol use in the U.S.^v; however this figure is a drastic underestimate since it excludes deaths from associated diseases such as drug injection-transmitted HIV/AIDS, and drug-related accidents and homicides.^{vi} Drug-related homicides alone accounted for 14,860 deaths in 2005.^{vii}

Untreated addiction is a key contributor to most crime. The U.S. makes up less than five percent of the world's population, yet almost four times as many drugs are seized in the United States (per person) than the global average, and the United States consumes cocaine at a rate of six times the global average.^{viii} This demand for illicit drugs fuels both domestic criminal activity and the international drug trade. . Between 60 and 80 percent of individuals under supervision of the criminal justice system in the U.S. were either under the influence of alcohol or other drugs when they committed an offense, committed the offense to support a drug addiction, were charged with a drug-related crime, or were using drugs or alcohol regularly.^{ix} Even discounting illicit drugs, alcohol was implicated in about one million violent crimes in 2002, according to victims who reported that the perpetrator had been drinking at the time of the offense.^x

Prevalence of Drug and Alcohol Problems and Need for Services

The impact of untreated drug and alcohol addiction on the nation's well-being is considerable. Addiction affects one in ten Americans and one in four children. In 2007, the National Survey on Drug Use and Health reported that an estimated 22.3 million Americans aged 12 or older, or 9.0 percent of Americans in that age group, met clinical criteria for substance dependence and needed treatment.^{xi} These numbers are conservative since they do not count homeless, incarcerated, and hospitalized populations.

In spite of the prevalence of alcohol and drug addiction, people often ignore the symptoms for years. In 2007, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) reported that nearly one third of Americans have an alcohol problem at some point in their lives. Of those with alcohol dependence, only 24 percent were ever treated, and even then, they did not receive treatment until an average of *10 years* after the onset of their problem.^{xii} Drug and alcohol addiction, when left undiagnosed and untreated, harms the individual physically, financially, emotionally, and socially. The damage extends to all whose lives intersect with the individual, including his/her family members, significant others, friends, employers, co-workers, and the extended community.

In addition, there is a wide gap between the need for services and the provision of them. Of the 22.3 million Americans with alcohol or drug problems in 2007, only 2.4 million—roughly one in ten—received treatment at a specialty treatment facility, leaving 21.1 million untreated. It can be especially difficult for special populations,

such as women, adolescents and veterans, to obtain necessary treatment and recovery support services. For example, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2002 an estimated two million veterans were dependent on or addicted to alcohol or illicit drugs. However, funding for healthcare services through the Department of Veterans Affairs (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 eight 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, fewer than 20 percent of veterans who needed addiction treatment received it. Meanwhile, the need for services for veterans returning from Iraq, Afghanistan, and other areas of conflict is increasing. The U.S. military reported 13,891 new cases of post-traumatic stress disorder (PTSD) in 2007, a 46.4 percent increase over 2006.^{xiii} With this spike in PTSD cases as well as depression, it is expected that the need for alcohol and other drug addiction treatment services for veterans will increase significantly.

Solutions to Our Nation's Drug and Alcohol Problems: The Benefits of Prevention, Treatment and Recovery Support

Fortunately, there are programmatic and policy solutions that effectively reduce demand and ease the burden of alcohol and drug addiction on taxpayers, communities, and institutions. These solutions are found in preventing alcohol and drug problems in the first place, detecting and treating it early, and supporting those who have overcome addiction so they remain clean and sober.

Prevention. Investment in alcohol and drug prevention reaps dividends: school-based drug prevention programs save \$5.60 in social benefits for every dollar invested.^{xiv} 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.^{xv})

Treatment. Like diabetes, hypertension, and asthma, addiction is a chronic illness that can be treated and managed. 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 also reduce incidences of HIV infection. Addiction treatment results also are sustainable. One year after completion of treatment, studies have shown a 67 percent reduction in weekly cocaine use, a 65 percent reduction in weekly heroin use, a 52 percent decrease in heavy alcohol use, a 61 percent reduction in illegal activity, and a 46 percent decrease in suicidal ideation. Moreover, these outcomes were generally stable for the same clients five years post treatment.^{xvi}

In addition to its clinical and social benefits, treatment is cost-effective. Taxpayers save at least \$7-\$12 in health care, criminal justice, and social costs for every dollar spent on treatment.^{xvii} With intervention and treatment, people with drug and alcohol problems can contribute to, rather than detract from, social and economic productivity.

Recovery Support. Because of the effects of addiction on the brain's decision-making patterns, people with addiction histories may require support to help them remain drug- and alcohol-free. Science shows that brain cravings for alcohol or drugs can be triggered by the sight, sound, smell, or recollection of things that were formerly associated with use. Until individuals develop new coping mechanisms and decision-making patterns, the external environment can be critical to their success in remaining clean and sober.

A number of elements in an individual's external environment can either help or hinder his/her sustained recovery. These elements may include, but are not limited to: employment, housing, education, vocational training, accountability mechanisms (i.e., threat of negative consequences), faith-based supports, and relationships. To create and sustain environments that are supportive of recovery, and to increase long-term treatment and recovery outcomes, these pro-social supports are essential. However, untold numbers of people who are seeking to overcome addiction lack the availability of and access to these supports, and falter in their recovery.

Barriers to Implementation of Solutions

The solutions for reducing demand are known. However, current barriers prevent full implementation of these solutions:

Barrier one: There is an inadequate supply of prevention, treatment, and recovery support services to meet the need.

Barrier two: Discrimination in employment, insurance, and other policies hinders people with addiction histories from successfully integrating into the community and becoming productive citizens.

Until these barriers are removed, drug and alcohol addiction will continue to have significant adverse consequences to Americans and the issues they care about most, including the economy, health care, and public safety.

Policy Reform Priorities

Prevention: Invest an additional \$1 billion per year, phased in over a five-year period, to implement a comprehensive, community-based prevention strategy targeting under-age drinking and other alcohol and drug misuse by the most at-risk populations, utilizing prevention initiatives that have proven successful for young people, families, communities, and schools.

Treatment and Recovery: 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. Begin by investing an additional \$4 billion annually, phased in over five years, to provide drug and alcohol treatment and recovery services to an additional one million Americans.

Veterans: Avoid the mistakes made during the Vietnam era by providing specialized prevention, treatment, and recovery support to veterans returning from Iraq and Afghanistan who are at suffering from or at high risk for post traumatic stress syndrome and alcohol and drug problems.

Criminal and Juvenile Justice and Child Welfare: Improve public safety, help children and families, and save tax-payer dollars by targeting prevention, treatment, and recovery support at young people and adults involved in the criminal and juvenile justice and child welfare systems. Mandated treatment for appropriate individuals is much more effective and less expensive than incarceration.

Discrimination: Help people in recovery from addiction maintain their recovery, reenter society successfully, and be productive tax-payers by eliminating unfair and counter-productive barriers to employment, insurance, food stamps, student loans, and other necessities of life. The first step should be enactment of the Paul Wellstone Mental Health and Addiction Equity Act.

FIVE KEY PRINCIPLES TO ADDICTION POLICY REFORM

The following principles are foundational to any policy or program strategies intended to reduce the damage of untreated drug and alcohol addiction in the United States:

- (1) **Addiction Is Preventable and Treatable.** The American Medical Association, National Institutes of Health, and other leading health authorities recognize and define alcohol and drug addiction as a preventable and treatable disease. This science should drive alcohol and drug policy.
- (2) **Equitable and Accessible Addiction Services are Integral to the Success of Health Care Reform, But Funding To Reduce Demand Has Fallen Far Behind.** Addiction prevention, treatment, and recovery services should be included in all health care plans and reform, and should be integrated into other systems including criminal justice, child welfare and housing.
- (3) **Prevention, Treatment and Recovery Support for All Who Need Them.** Alcohol and drug addiction touches families and communities at all levels of society, and services must be made available for all who need them. Every child needs alcohol and drug prevention services and organized communities that can strengthen prevention strategies
- (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. 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 their addiction history. Discrimination in housing, employment, and other areas not only impedes recovery, but, because of the manner in which many laws are written, also has a disproportionate impact on communities of color.

**POLICY REFORM RECOMMENDATIONS
TABLE OF CONTENTS**

I. EXPAND AND IMPROVE HEALTH RESPONSE TO ADDICTION	12
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	12
1. Increase the capacity of 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 provides equal, non-discriminatory insurance coverage of addiction treatment.	12
2. Through broad-scale employee recruitment, training, and retention efforts, strengthen current workforce capacity to address needs for prevention, treatment and recovery services. Such initiatives would include the creation of a loan forgiveness program for addiction professionals	12
3. As an effective and cost-efficient sentencing alternative to incarceration, provide supervised treatment for all addicted persons charged with or convicted of non-violent offenses	15
4. Assure quality of treatment and recovery support services by funding state-of-the-art practices that have been proven effective	16
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 five-year period, the U.S. could support a comprehensive, community-based prevention strategy targeting the most at-risk populations	17
1. Establish drug and alcohol prevention coalitions to serve every community Nationwide; begin by funding 1,750 new coalitions over five years	18
2. Double school-based programming targeting youth, parents and educators, including prevention for an additional 6.6 million middle and high school students.	19
3. Create access to prevention services for all high-risk youth by annually expanding student assistance services by an additional 1.2 million youth over five years	21
4. Expand higher education prevention and education programs targeting high-risk behavior of college students	21

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	22
II. ELIMINATE DISCRIMINATION AGAINST PEOPLE IN RECOVERY	23
A. Eliminate discrimination based on alcohol/drug history	24
1. Require parity in insurance coverage and reform managed care practices so that everyone who is addicted can obtain the appropriate care	24
2. Protect individuals in early recovery and those willing to enter treatment from employment discrimination	24
3. Restore eligibility for Social Security disability benefits for individuals with a primary diagnosis of addiction	25
B. Eliminate discrimination against people with criminal histories who are qualified and have paid their debt to society	
1. Fund and enforce the Second Chance Act to begin a review of discriminatory barriers and assist the re-entry into society of people with criminal records	25
2. Repeal unfair federal- and state-based barriers to obtaining food stamps, public benefits, student loans, employment, housing, and voting rights	25
▪ Eliminating the ban on Temporary Assistance for Needy Families (TANF/welfare) and food stamp benefits for individuals with drug felony convictions	26
▪ Fully repealing the student financial aid ban for individuals with drug convictions	27
▪ Strengthening post-secondary educational opportunities for people reentering from incarceration	27
▪ Removing barriers to employment for individuals with criminal records	28
▪ Removing unfair legal, policy and practical barriers to housing	29
▪ Promoting civic participation and rehabilitation by providing full and fair voting rights to individuals who are no longer incarcerated	29
3. Eliminate mandatory incarceration and mandatory minimum sentences for drug crimes in order to give courts flexibility in sentencing individuals with an addiction to alcohol and drug treatment and other successful alternatives to incarceration that break the cycle of addiction and crime	30

POLICY REFORM RECOMMENDATIONS

Health policy reform can save tens of thousands of lives as well as billions of dollars – and strengthen families and communities across the country – with two important steps: (1) Expand and improve health responses to addiction; and (2) Eliminate discrimination against people in recovery. These overarching recommendations are presented in detail below.

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.

Because research shows that a health care approach is the most effective means to reduce drug and alcohol addiction and its damaging consequences, invest an additional \$4 billion annually, phased in over five years, to provide drug and alcohol treatment and recovery services to an additional one million Americans.

1. Increase the capacity of 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 provides equal, non-discriminatory insurance coverage of addiction treatment.

Programs that serve individuals with alcohol and drug addiction depend almost 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 other health problems at nearly three times that rate (36 percent).

Below are descriptions of the public and private programs that make up the vast majority of financial support for drug and alcohol treatment and support services.

Substance Abuse Prevention and Treatment (SAPT) Block Grant

The backbone of 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 indicate that the SAPT Block Grant serves nearly two million people every year and 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, along with increasing other federal treatment and prevention programs targeting special populations, could help to support the overall expansion of national access to drug and alcohol treatment and prevention services.

Medicaid

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 on welfare and families involved in the child welfare system. However, Medicaid coverage for alcohol and drug treatment services is unnecessarily limited and should be enhanced:

- ***Make 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 for States, 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. Implementing this policy change 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.

- ***Lift 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 intent 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 IMDs lose their Medicaid eligibility for all Medicaid reimbursable services, including prenatal and HIV care, while they remain in the facility. These are 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 eliminate a significant barrier to funding for critical residential programs that treat both individuals and families.

Private Insurance

Like diabetes, asthma or hypertension, addiction is a chronic disease and paying for its treatment yields returns that are comparable to paying for treatment for other chronic illnesses. In 2007, of the 17.4 million adults over the age of 18 classified with substance dependence, 75.3 percent (13.1 million) were employed either full or part time.^{xviii} 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 can be a chronic, relapsing condition when its symptoms are ignored – 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. Based on combined data between 2004 and 2007, 31.1 percent of the individuals who were unable to receive treatment after making an effort to, reported that the cost and/or health insurance barriers prevented them from gaining access to treatment.^{xix}

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 appropriate alcohol, drug and mental health treatment is imperative.

Almost a decade ago, 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 nine 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

learned can be applied to strengthen any future parity or managed care reform implemented at the federal or state level.

Efforts to pass meaningful addiction and mental health parity legislation continue during this 110th Congress, with key bi-partisan negotiators in the House and the Senate recently reaching agreement about the provisions of the legislation. The current mental health and addiction parity legislation would ensure:

- Meaningful equity with medical and surgical benefits in the provision of alcohol/drug treatment and mental health benefits for both in- and out-of-network benefits;
- The provision of medical necessity criteria and reasons for any denials of reimbursement to participants and beneficiaries upon request; and
- 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.

It is critically important that Congress pass this mental health and addiction parity legislation before the end of the 110th Congress.

While broad insurance reform and public health care program restructuring is a large and long-term task that is urgently needed, drug and alcohol addiction prevention and treatment 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 one million Americans annually – five percent of those who are underserved – and phased in service expansion over five years, it would cost approximately \$4 billion per year. With a cost savings on \$7-\$12 per dollar spend on treatment, the investment of the first \$4 billion would yield \$28 to 48 billion in projected savings in health care and social costs.

2. Through broad-scale employee recruitment, training, and retention efforts, strengthen current workforce capacity to address needs for prevention, treatment and recovery services. Such initiatives would include the creation of a loan forgiveness program for addiction professionals.

As prevention, treatment and recovery services are incrementally increased to better meet the need, so too must there be strategic development of the workforce to provide these services, including employee recruitment, training, and retention on a broad scale. There are a number of workforce challenges confronting the field at this time, including a shortage of workers, the aging of the current workforce, inadequate counselor salaries, the need for a more diverse, culturally competent workforce, and the continuing stigma associated with addiction. Recruitment, training, and retention of the addiction treatment workforce are key to the long-term improvement of treatment quality and outcomes.

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, there is a pressing need to apply what is now known about treatment and recovery into practice. In the past 15 years, there has been a virtual explosion of knowledge regarding the causes and responses to addiction, thanks to advanced research on the impact of addiction on the brain. With this knowledge has come a growing body of scientific research related to evidence-based practice – techniques that have been proven effective at preventing and treating addiction – that now must be transferred, taught, and implemented in the field. These include, for example, cognitive-behavioral interventions and the utilization of medications in treatment (such as buprenorphine for opiate addiction). There is also an important movement toward recovery-oriented systems of care, wherein all the social systems and service providers that touch the addicted individual are mutually focused on the individual’s and his/her family’s success in overcoming addiction.

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 this field.
- 3. As an effective and cost-efficient sentencing alternative to incarceration, provide supervised treatment for all addicted persons charged with or convicted of non-violent offenses.**

Research has shown that between 60 and 80 percent of individuals under the 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 only the first of many stages 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, based on clinical criteria, placing those who are eligible for diversion or pretrial release into appropriate community-based treatment and recovery support.
- Expanding court-based programs that provide supervision, monitoring, and access to appropriate treatment and support services for addicted individuals who are arrested or convicted of non-violent offenses. Successful, replicable program models include drug courts, Breaking the Cycle, and TASC (Treatment Alternatives for Safer Communities).^{xx xxi}
- Expanding treatment, aftercare, and community-based recovery support services for individuals who are incarcerated and returning to the community. 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 state-of-the-art practices that have been proven effective.

The field of drug and alcohol addiction treatment in its current form began to take shape in the 1970s, when many of the organizations and associations that exist today were founded. Over the past 15 years in particular, new science and technologies have emerged to improve the delivery and effectiveness of quality treatment and recovery support services. The funding of new and proven treatment techniques, including emerging medications, will facilitate putting best practices into place. Without additional treatment funding, however, providers are often unable to put to use some of the very methods that are known to be most effective.

Providing access to the full continuum of treatment and care is also essential to promoting effectiveness. Drug and alcohol addiction treatment entails various levels of care, ranging from detoxification to outpatient to residential treatment to aftercare and

recovery support. It is important for individuals to be in the right level of care, not only to ensure good clinical outcomes, but also to ensure that limited treatment resources are used most effectively. When an adequate range of treatment services is not available, this can delay entrance into the next appropriate level of care for a patient, causing unnecessary expenditures at one level of care while a patient waits for a treatment slot to open at the next level. For example, some third party payors fund detoxification services but do not fund other levels of treatment. Not only is clinically ineffective, but it sets up the patient to fail since detoxification only clears the body of addictive substances, but does not address the psychological and behavioral aspects of addiction.

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. Likewise, engaging and collaborating with recovery support service providers is an essential aspect of translating knowledge to practice. Experience has shown that just as addiction affects a wide circle of family, friend, employers, and community, the recovery process must also engage these same partners. In addition, those who are “in recovery” – people who have successfully overcome addiction – not only play an indispensable role in effectively engaging and retaining clients in treatment, aftercare and relapse prevention, but in guiding and shaping the future directions of the field.

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. It will also 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 five-year period, the U.S. could support a comprehensive, community-based 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 SAMHSA and the National Institute on Drug Abuse (NIDA), the younger a person first uses drugs or alcohol, the higher his/her 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.^{xxii} 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.^{xxiii} Similarly, of youth who began drinking before age 15, 40 percent were classified as dependent later in life, whereas of those youth who began drinking between the ages of 17 and 21, 24.5 percent were classified as dependent, and of those youth who began drinking at age 21 or 22, 10 percent were classified as dependent.^{xxiv} Youth who drink or use drugs are also at risk for many other harmful behaviors, including increased risky sexual activity, violence, and school problems such as school dropout. 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.^{xxv}

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 effect 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. 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.^{xxvi} Millions of young people are never touched by prevention and early intervention programs that have proven to be effective.

To implement a comprehensive community-based prevention strategy, federal, state, and local governments should:

1. Establish drug and alcohol prevention coalitions to serve every community nationwide; begin by funding 1,750 new coalitions over five years.

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 that address drug use and underage drinking are a necessary component of the community-based infrastructure for prevention.

The Drug Free Communities (DFC) program has been a central, bipartisan component of our nation's demand reduction strategy since its passage in 1998 because it recognizes that the drug issue must be dealt with in every hometown in America. It now supports over 700 drug-free community coalitions across the United States. Through its support for community coalitions nationally, the DFC program has proven effective in reducing youth drug use rates in communities throughout the country and has done so with a minimal investment of federal funds. In addition to its local successes, the DFC program as a whole is achieving remarkable success at the national level. In fact, according to a recent national evaluation, **communities with DFC-funded coalitions have statistically significant lower usage rates than those communities without.**

Housed in the Office of National Drug Control Policy, the DFC program provides the funding necessary for communities to identify and respond to local drug and alcohol use problems, and empowers local citizens to get directly involved in solving their own community's drug issues by marrying grassroots community organizing with data-driven planning and implementation. The DFC Act does not specifically define what is meant by "community," but instead allows applicants to self-select the parameters of the community covered by their grant; under the DFC Act, cities, as units of local government closest to the community level, are used as a proxy measure for communities. DFC grantees are singularly situated to deal with emerging drug trends, such as methamphetamine, "cheese," and prescription drug misuse because they have the necessary infrastructure in place to effectively prevent and address substance use within their communities: they are organized, data driven and take a comprehensive, multi-sector approach to solving and addressing substance use and abuse issues.

However, despite exponential growth since the program's inception in FY 1998, funds have only been available to support less than one third of those communities who apply for DFC grants,^{xxvii} while at the same time requiring a dollar-for-dollar local non-federal match to ensure community buy-in and program sustainability.^{xxviii} To date, a total of 1,321 coalition grants have been funded since the program began in 1998. To ensure full national coverage of the DFC coalition infrastructure, every city in the country should eventually be supported by at least one community anti-drug coalition. The total number of additional coalitions needed to ensure every city is served by at least one DFC coalition is 36,911.^{xxix}

To begin to meet this need we recommend that five percent of the total universe of coalitions, or 1,750 new coalitions (350 per year) be funded over the next five years.

Five hundred of these coalitions (or 100 per year) will be supported with funds from grants that expire during this time period. The total annual investment for 350 new coalitions per year would be \$43,750,000, of which \$12,500,000 would be supported with funds from grants that expire and \$31,250,000 would be in new appropriations. The total investment in the 1,750 new coalitions over a five year period would be \$1,093,750,000, of which only \$781,250,000 would be in new appropriations.

While this is a substantial investment, research demonstrates that effective substance abuse prevention, such as the DFC program, can yield major economic dividends. The savings per dollar spent on substance abuse prevention can be significant and range from \$2.00 to \$20.00. Therefore, if 1,750 new coalitions are funded over the next five years, this new investment could potentially contribute to a net savings of between \$1.563 billion and \$15.625 billion.

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

Drug, alcohol and tobacco use cost schools throughout the country an extra \$41 billion per year in truancy, violence, disciplinary programs, school security and other expenses.^{xxx} Recent evidence supports the fact that “social and emotional learning” programs increase academic achievement, and help students avoid engaging in high-risk behaviors such as illegal drug use.^{xxx1} The primary federal program currently funding “social and emotional learning” programs is the Safe and Drug Free Schools and Communities (SDFSC) program.

The State Grants portion of the SDFSC program is the backbone of youth drug prevention in the United States and is the portal into schools for all drug and violence prevention activities. The program, which provides peer resistance and social skills training, student assistance, parent training, and education about emerging drug trends, serves more than 37 million youth per year in every school district in America. Funds from the SDFSC program are used to recruit partners who commit additional resources and manpower to make programs optimally effective for their communities. The program has historically been a catalyst for community involvement, volunteerism and the leveraging of funding from other sources to address drug and violence prevention and intervention in states throughout the country.

The average cost for implementing evidence based programming for alcohol and drugs at the years of highest risk, with a booster before college is approximately \$743.2 million per year or more than two and one half times the total current allocation of \$294.8 million of the State Grants portion of the SDFSC program.^{xxxii} 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. **Youth drug use was at its lowest point in 1992 when the investment in the SDFSC program was the highest.**

Study findings link lower reading and math scores to peer substance use. On average, students whose peers avoided substance use had test scores (measured by the Washington Assessment of Student Learning reading and math scores) that were 18 points higher for reading, and 45 points higher for math.^{xxxiii} **Every new cohort of youth must have the benefit of effective alcohol and drug abuse prevention. As a nation, we must make a sustained and substantial investment in delaying the age that American youth start to use alcohol and illegal drugs.**

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

There are approximately six 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 are 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.^{xxxiv}

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*^{xxxv}, also found that 1.8 million full-time college students (22.9 percent) meet the medical criteria for substance dependence, two and one half times the number of the general population.^{xxxvi}

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 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 percent over five years in order to better address unmet treatment demand and 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 examples such as:

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

With funding for the above recommendations, the fields of substance use prevention, and addiction treatment and recovery can work collaboratively with policymakers, social service and government institutions, and community leaders to assure better informed, science-driven approaches to preventing and treating drug and alcohol addiction.

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 percent of people in recovery – those who have successfully overcome addiction to alcohol or other drugs – report suffering discrimination in employment, insurance, or both.^{xxxvii} Such discrimination reflects the myths that many believe about addiction – that it is not a preventable and treatable disease from which there can be a productive, successful, and sustained recovery.

Society perpetuates this stigma when it promulgates laws and policies that discriminate against individuals with a past 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. Eliminating this discrimination would both reduce the stigma of addiction and create 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 appropriate care.** (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 seek 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 imperative 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, three quarters of people with drug and alcohol 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 against people with criminal histories who are qualified and have paid their debt to society:

1. Fund and enforce 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, two million people were incarcerated in Federal or State prisons or in local jails.^{xxxviii} Each year, nearly 650,000 people are released from State and Federal prisons, and many more from county jails, back into communities nationwide.^{xxxix}

Criminal records create barriers to successful community reentry: 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 of the nation’s adults have a criminal record, making it more difficult for qualified individuals to gain employment, housing, and access to public benefits.^{xi}

A strong reentry/transition process – through which individuals are prepared for release, leave prison, return to communities, and adjust to free living – is needed to enhance public safety.^{xli} Ninety-seven percent of the individuals now in prison eventually will be released and will return to communities,^{xlii} 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.^{xliii} 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 and housing, and to reduce recidivism.

When formerly incarcerated individuals are not provided re-entry services, they are likely to 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 percent it would save \$6.8 million a year in jail costs alone.^{xliv} Again, successful community reentry models that reduce recidivism exist, such as the research-based Sheridan model in Illinois. Since the program's inception in 2004, formal evaluation has shown participants to be 40 percent less likely than other parolees to return to prison.

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.

Funding the "Second Chance Act," re-entry legislation that was signed by the President in April 2008, 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. 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. Currently, 14 States completely deny benefits on the basis of this ban and 22 States have modified the ban in some way. 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. 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.

- ***Strengthening post-secondary educational opportunities for people reentering from incarceration.***

Education is one of the best deterrents to re-offending. In a study conducted for the U.S. Department of Education, researchers found that participation in state correctional education programs lowers the likelihood of re-incarceration by 29 percent.^{xlv} In addition, this study concluded that for every dollar spent on education, more than two dollars in reduced prison costs would be returned to taxpayers.

In addition, advanced educational opportunities will help to prepare formerly incarcerated individuals to compete in the labor market, join the workforce, and positively contribute to the economy. Employment reduces recidivism and increases the chance that a formerly incarcerated person will successfully transition into the community.

In 1994, Congress eliminated eligibility for people in state and federal correctional facilities to receive Pell Grants to help finance post-secondary education. This change was made despite clear research showing that incarcerated individuals who receive a post-secondary education prior to their release from incarceration are much less likely to recidivate and are more likely to successfully reintegrate back into the community.

Reinstating Pell Grant eligibility to incarcerated people who are nearing release would better help individuals obtain the educational and employment skills needed to successfully reenter the community from incarceration.

- ***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 lock out and eliminate 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 is easier to reject to all people with conviction records than to perform individualized analyses of their applications. These policies 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, court orders that declare a formerly incarcerated person is now rehabilitated, 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 four 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 individuals with an addiction to alcohol and drug treatment and other successful alternatives to incarceration that break the cycle of addiction and crime.**

As shown earlier, 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. 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. 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.

CONCLUSION

Untreated drug and alcohol addiction affects every American. Addiction hurts individuals, families, communities, and the entire country when we as a nation must pay the high cost of our neglect. Untreated drug and alcohol addiction is responsible for over 120,000 deaths each year and has been a factor in crimes committed by 80 percent of individuals in the criminal justice system. Furthermore, many drug laws disproportionately affect Blacks and Latinos, perpetuating the cycle of incarceration and disenfranchisement among some minority populations in the United States.

In order to stop the cycle of addiction, crime, and incarceration, we must reform our federal and State policies to expand and improve health responses to addiction, and to end discriminatory practices against people in recovery from drug and alcohol addiction.

We must adequately invest in drug and alcohol prevention, treatment, and recovery support services and support additional scientific research. Money spent on drug and alcohol prevention and treatment services reaps savings and eases the burden on taxpayers: research has shown that the cost of incarcerating an individual for a drug-related crime is 15 times greater than the cost of addiction treatment. Research has shown that many individuals who later become addicted to drugs and alcohol first begin experimenting with illicit substances at an early age. Investing in strong prevention initiatives that target at-risk youth would diminish the number of people who later will struggle with drug and alcohol addiction. In addition, like other diseases, addiction is a health condition that can be managed and treated. Investing in addiction treatment reduces drug and alcohol use, the incidence of crime, and the spread of HIV. In order to ensure individuals remain drug- and alcohol-free after completing treatment programs, we must continue to offer long-term, community-based recovery services.

In order to reduce the instances of drug and alcohol addiction and the accompanying damage to individuals and communities, not only must prevention, treatment, and recovery services be offered, but we must also address the discrimination that individuals in recovery face when trying to find housing, employment, and reenter society as productive citizens. Ridding society of these unfair policies would help support those individuals who need access to treatment and who are living in recovery. Eliminating this discrimination would both reduce the stigma of addiction and create access to a wide variety of legal protections and public programs that contribute substantially to a person's ability to gain and maintain recovery.

Implementing these policy changes will strengthen our families and communities, and will reduce rates of crime and recidivism. In addition, eliminating policies that discriminate against people in recovery and those with criminal records will help millions of Americans now struggling with drug and alcohol addiction find a path to recovery and will help the hundreds of thousands of people reentering the community each year from the criminal justice system will become productive members of society.

ENDNOTES

- ⁱ See NIDA chart showing \$161B on abuse of illicit drugs, and \$185B spent on abuse of alcohol. <http://www.nida.nih.gov/about/welcome/aboutdrugabuse/magnitude/> Also see December 2004 ONDCP report, which estimates the cost of illicit drug abuse alone to be \$180.9 billion. http://www.whitehousedrugpolicy.gov/publications/economic_costs/e_summary.pdf.
- ⁱⁱ \$128.6 billion in lost productivity plus \$15.8 billion in substance use-related employee health care costs. See second paragraph under “Employee Assistance is Cost Effective” http://www.hbo.com/addiction/treatment/374_battling_addiction.html
- ⁱⁱⁱ Ibid.
- ^{iv} See DAWN report highlights at <http://dawninfo.samhsa.gov/files/DAWN2k4ED.htm#High3>
- ^v Department of Health and Human Services Fact Sheet, “SUBSTANCE ABUSE -- A NATIONAL CHALLENGE: PREVENTION, TREATMENT AND RESEARCH AT HHS.” January 13, 2006. <http://www.hhs.gov/news/factsheet/subabuse.html>
- ^{vi} RWJ report, pages 6 and 54: <http://www.rwjf.org/files/publications/other/SubstanceAbuseChartbook.pdf>
- ^{vii} <http://www.ojp.usdoj.gov/bjs/dcf/duc.htm>
- ^{viii} 2006 World Population Data Sheet: <http://www.prb.org/Search.aspx?q=u.s.%20as%20percent%20of%20world%20population>
The United Nations Office on Drugs and Crime “2007 World Drug Report” at <http://www.unodc.org/unodc/en/data-and-analysis/WDR-2007.html>. (pg. 35, 88).
- ^{ix} “Substance abuse and the prison population: A three-year study by Columbia University reveals widespread substance abuse among the offender population.” *Corrections Today*, 60(6), 82-89, Belenko, S., Peugh, J., Califano, J.A., Usdansky, M., & Foster, S.E. (1998) as cited in “Integrating Substance Abuse Treatment and Criminal Justice Supervision,” Douglas B. Marlowe, J.D., Ph.D. NIDA Science and Practice Perspectives, Volume 2, Number 1 – September 2003, <http://www.drugabuse.gov/PDF/Perspectives/vol2no1/02Perspectives-Integrating.pdf>
- ^x http://www.ojp.usdoj.gov/bjs/cvict_c.htm
- ^{xi} <http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.pdf>
- ^{xii} <http://www.nih.gov/news/pr/jul2007/niaaa-02.htm>
- ^{xiii} <http://www.jointogether.org/news/headlines/inthenews/2008/spike-in-ptsd-cases-among.html>. See also veterans bill just passed by Senate: <http://www.jointogether.org/news/headlines/inthenews/2008/veterans-bill-addresses.html>
- ^{xiv} http://maryland-adaa.org/content_documents/2003-61.pdf
- ^{xv} Swisher, John. (2004). *Journal of Primary Prevention*. “Cost-benefit estimates in prevention research.” (25)12.
- ^{xvi} 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.
- ^{xvii} Principles of Drug Addiction Treatment: A Research Based Guide, National Institute on Drug Abuse, <http://www.nida.nih.gov/PODAT/PODAT6.html#FAQ11>
- ^{xviii} <http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.pdf>
- ^{xix} <http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.pdf>
- ^{xx} The ONDCP website discusses the TASC and drug court models under “Alternatives to Incarceration” <http://www.whitehousedrugpolicy.gov/publications/factsht/treatment/index.html>.
- ^{xxi} The NCJRS website offers an evaluation of the Breaking the Cycle model: <http://www.ncjrs.gov/pdffiles1/nij/grants/189244.pdf>
- ^{xxii} 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.
- ^{xxiii} 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.
- ^{xxiv} 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.

-
- ^{xxv} 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.
- ^{xxvi} 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>.
- ^{xxvii} Historically, program funding has only supported 32.6% of the communities that applied for DFC funding (1321 out of 4054).
- ^{xxviii} Federal support by law is contingent upon a community raising a local dollar-for-dollar match to address its drug problem. Communities funded under the DFC program receive grants for a five-year period. The maximum grant award amount for one year is \$125,000.
- ^{xxix} According to the National Census Bureau, there are a total of 38,232 cities/townships in the United States. Given that there are currently 1,321 DFC grantees, this number was subtracted from 38,232 to determine that in order for every city in the country to eventually be served by a minimum of one coalition per city, an additional 36,911 coalitions are needed.
- ^{xxx} U.S. Department of Health and Human Services and Education and SAMHSA's National Clearinghouse for Alcohol and Drug Information. (2002). *Prevention Alert*. "Schools and Substance Abuse (I): It Costs \$41 Billion." 5(10). Available: <http://www.health.org/govpubs/prevalert/v5/5.aspx>.
- ^{xxxi} Zins, J.E., Payton, J.W., Weissberg, R.P., & O'Brien, M.U. (2007). In G. Matthews, M. Zeidner, & R. D. Roberts (Eds.), *The science of emotional intelligence: Knowns and unknowns*. New York: Oxford University Press.
- ^{xxxii} 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.
- ^{xxxiii} Bence, M., Brandon, R., Lee, I., Tran, H. University of Washington. (2000). *Impact of peer substance use on middle school performance in Washington: Summary*. Washington Kids Count/University of WA: Seattle, WA. Available: http://www.hspsc.org/wkc/special/pdf/peer_sub_091200.pdf
- ^{xxxiv} 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.)
- ^{xxxv} "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>
- ^{xxxvi} 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>
- ^{xxxvii} "The Face of Recovery," Peter D. Hart Research Associates, October 2001
- ^{xxxviii} BJS, <http://www.ojp.usdoj.gov/bjs/prisons.htm>
- ^{xxxix} Office of Justice Programs (OJP) website, www.ojp.usdoj.gov/reentry/learn.html
- ^{xl} "Use and Management of Criminal History Record Information: A Comprehensive Report, 2001 Update," <http://www.ojp.usdoj.gov/bjs/pub/ascii/umchri01.txt>
- ^{xli} National Institute of Corrections, <http://www.nicic.org/resources/topics/TransitionFromPrison.aspx>
- ^{xlii} Id.
- ^{xliii} 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.
- ^{xliv} See supra note vii.
- ^{xlv} Correctional Education Association report for the U.S. Department of Education, "The Three State Recidivism Study". Steurer, Smith and Tracy, 1997